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ABSTRACT

This report summarizes available information on the incidence of child abuse among children with disabilities, relationships between child abuse and disability, and the incidence of disabilities resulting from child abuse or neglect. Much of the information in the report comes from data collected on 1,249 substantiated cases of maltreatment involving 1,834 children. Among major findings were: (1) the incidence of maltreatment among children with disabilities was 1.7 times higher than for children without disabilities; (2) for 47 percent of the maltreated children with disabilities, caseworkers reported that the disabilities directly led to or contributed to the child maltreatment; and (3) the incidence of disabilities caused or likely to have been caused by maltreatment was 147 per 1,000 maltreated children. It is recommended that: risk assessment approaches should include the child's disabilities as a risk factor; caseworkers and other professionals should be educated on the relationship between maltreatment and disabilities; and state and federal systems for reporting cases of child maltreatment should include uniform information on disabilities. The report's three sections review previous research and explain the study's methodology; consider the incidence of maltreatment among children with disabilities; and present data on maltreated children with disabilities, characteristics of children, characteristics of adults, and case processing. Appendices provide further methodological detail, the two data collection instruments, and a glossary of terms. (Contains 35 references.) (DB)

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ED 365 089

A REPORT ON THE MALTREATMENT OF CHILDREN WITH DISABILITIES

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A REPORT ON THE MALTREATMENT OF CHILDREN WITH DISABILITIES

EXECUTIVE SUMMARY

Background

An estimated 23 out of every 1,000 children in the United States are maltreated each year (Westat, Inc., 1988). This report focuses on those maltreated children who have the additional hardship of prior physical, intellectual, or emotional disabilities. It was prepared in response to Section 102(a) of the Child Abuse Prevention, Adoption, and Family Services Act of 1988 (P.L. 100-294). This law required that the National Center on Child Abuse and Neglect (NCCAN):

- Report the incidence of child abuse among children with disabilities;
- Identify relationships between child abuse and the children's disability; and
- Report on the incidence of children who have developed disabilities as a result of child abuse or neglect.

Much of the information in this report is based on data collected from 35 Child Protective Services (CPS) agencies statistically selected to be nationally representative. Each of these agencies was asked to provide information on all cases of substantiated maltreatment over a 4- to 6-week time period in early 1991. Information was collected on 1,249 cases involving 1,834 children (a case may involve more than one child) whose maltreatment was substantiated. Follow-up interviews were conducted with caseworkers responsible for these cases during the summer of 1991.

The terminology for "disabilities" varies across professions and disciplines. The report uses the current terminology, which is found in the Americans with Disabilities Act (P.L. 101-336), rather than the terminology found in P.L. 100-294. Children were considered to have a disability if two criteria were met: (a) they were suspected of being mentally retarded, hard of hearing, deaf, speech impaired, visually impaired, blind, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, or of having specific learning disabilities or multiple disabilities; and (b) who, because of those impairments, had limited functioning in one or more life activities, including mobility, self-care, receptive and expressive language, learning, self-direction, capacity for independent living, and economic self-sufficiency.

Major Findings

Major findings from this study include:

- The incidence of maltreatment (number of children maltreated annually per 1,000 children) among children with disabilities was 1.7 times higher than the incidence of maltreatment for children without disabilities.
- For 47 percent of the maltreated children with disabilities, CPS caseworkers reported that the disabilities directly led to or contributed to child maltreatment.
- CPS caseworkers reported that a disability led to or contributed to maltreatment for 67 percent of the maltreated children with a serious emotional disturbance, 76 percent of those with a physical health problem, and 59 percent of those who were hyperactive.
- The incidence of disabilities that were caused or were likely to have been caused by maltreatment is 147 per 1,000 maltreated children.
- For 37 percent of the maltreated children with maltreatment-related injuries, CPS caseworkers reported that maltreatment definitely contributed to or was likely to have led to disabilities.
- Of the maltreated children with maltreatment-related injuries, CPS caseworkers reported that maltreatment definitely contributed to or was likely to have led to disabilities for 62 percent of the children who experienced sexual abuse, 48 percent of those who experienced emotional abuse, and 55 percent of those who experienced neglect.
- Among children whose maltreatment had been substantiated by CPS agencies, children with disabilities differed from children without disabilities in demographic characteristics and in the incidence of type of maltreatment.
- Of the maltreated children with maltreatment-related injuries, only 38 percent of those who experienced sexual abuse and 45 percent of those who experienced neglect were judged by CPS caseworkers as unlikely to have developed disabilities as a result of the maltreatment or as not to have developed disabilities as a result of the maltreatment.
- About 42 percent of the families of maltreated children with disabilities were known to a CPS agency as a result of maltreatment reports received prior to the maltreatment that was recorded in the study.
- CPS caseworkers were more likely to keep cases open longer after substantiation for children with disabilities as compared with children without disabilities.

Specific findings are provided as follows.

Incidence of Maltreatment Among Children with Disabilities

- For the representative sample of maltreated children studied, 36 per 1,000 children with disabilities were maltreated. This rate was 1.7 times higher than the rate for children without disabilities. Maltreatment included physical, sexual, and emotional abuse, as well as physical, educational, and emotional neglect.

- The incidence of emotional neglect among maltreated children with disabilities was 2.8 times as great as for maltreated children without disabilities.

- Among maltreated children who were physically abused, 17 percent had disabilities and 83 percent did not have disabilities. The incidence of physical abuse among maltreated children with disabilities was 9 per 1,000, a rate 2.1 times the rate for maltreated children without disabilities.

- Among maltreated children with disabilities, the incidence of sexual abuse was 3.5 per 1,000 children, a rate 1.8 times the rate for maltreated children without disabilities.

- Among maltreated children with disabilities, the incidence of physical neglect was 12 per 1,000, a rate 1.6 times the rate for maltreated children without disabilities.

Demographic Characteristics/Types of Maltreatment

- The most frequent disabilities among children whose maltreatment was substantiated by a CPS agency were serious emotional disturbance, learning disability, and speech or language delay or impairment.

- Among children whose maltreatment had been substantiated by a CPS agency, children with disabilities were more likely to be male, White, from one-child families, and over the age of 4 than were children without disabilities.

- Among children whose maltreatment had been substantiated by a CPS agency, children with disabilities were more likely to have been medically neglected but less likely to have been physically neglected than were children without disabilities.

- Among children whose maltreatment had been substantiated by a CPS agency, primary caretakers of children with disabilities were less likely to have been involved in the maltreatment than primary caretakers of children without disabilities (14 percent vs. 24 percent).

Case Processing for Children with Disabilities

- Among children whose maltreatment had been substantiated by a CPS agency, 42 percent of the families with children with disabilities and 39 percent of the families with children without disabilities had previous allegations of maltreatment.
- Among children whose maltreatment had been substantiated by a CPS agency, children without disabilities were more likely to be in cases that closed immediately after CPS agency substantiation than were children with disabilities (29 percent vs. 15 percent).
- Among children whose maltreatment had been substantiated by a CPS agency, the mean length of time for cases to remain open before closing during the first 90 days after substantiation was 46.1 days for children with disabilities and 48.9 days for children without disabilities.

Recommendations

- Risk assessment approaches used in CPS agencies should include the child's specific disabilities as a risk factor.
- CPS caseworkers should be educated on the relationship between maltreatment and disabilities, on identifying disabilities, and on making appropriate referrals for children with disabilities.
- Professionals who come into contact with children with disabilities should be educated on the relationship between maltreatment and disabilities, on identifying possible child maltreatment, and on making appropriate referrals for these children.
- State and Federal systems for reporting information on cases of child maltreatment should include uniform information on whether or not children have disabilities.
- Caseworkers in CPS agencies and professionals in other settings should provide specialized services to prevent maltreatment in families with children with disabilities.

1. INTRODUCTION

Of the estimated 23 out of every 1,000 children in the United States who are maltreated each year (Westat, Inc., 1988), many have the additional hardship of prior physical, intellectual, or emotional disabilities. As mandated by Section 102(a) of P.L. 100-294, the Child Abuse Prevention, Adoption, and Family Services Act of 1988, the Congress directed the National Center on Child Abuse and Neglect (NCCAN) to conduct a study and report on the incidence of child abuse among children with disabilities, on the relationship between child abuse and children's disabilities, and on the incidence of children who have developed disabilities as a result of child abuse or neglect.

1.1 Previous Research on Child Maltreatment and Disabilities

While anecdotal reports and small scientific studies suggest that children with disabilities may be at especially high risk for maltreatment, the extent and nature of this problem at the national level has been unknown. The literature that does exist on disabled children who are maltreated focuses on two issues of child abuse and neglect:

- Are children with disabilities at greater risk of experiencing child abuse and neglect than children without disabilities?
- Are children who are abused or neglected at increased risk of developing disabilities as a consequence of their maltreatment?

Many observers have argued that the special characteristics of children with disabilities may put them at increased risk of abuse and neglect (e.g., Kirkham et al., 1986; Scholz, 1983). Schinke et al. (1981) observed how adequate care for persons without disabilities may constitute neglect for those who are mentally retarded. Schilling and Schinke (1984a-b) pointed out that special needs children make special demands that may contribute to a parent's stress level and subsequent loss of control. Communication deficits, common among developmentally disabled children, also increase the likelihood of abuse or neglect of children with disabilities. Poor judgment and social naivete exhibited by some persons with cognitive limitations also place them at risk for sexual exploitation and emotional abuse.

Even within the context of the field of child maltreatment, which has been criticized for relying on small and poorly controlled studies, research on maltreatment of children with disabilities is scarce. While the topic has received attention, only a few recent methodologically sound studies have been conducted. For example, an entire volume on maltreatment of children with disabilities (Garbarino, Brookhouser, Authier, and Associates, 1987), edited by one of the most respected authorities on child abuse, includes a dozen chapters. The editors assembled a scholarly, serviceable, and timely collection of papers that consider the special risks faced by children with developmental disabilities. Garbarino et al. opens the book by grounding issues related to children with disabilities in a larger context of child maltreatment in general. Drawing on their own earlier reviews of the child abuse knowledge base, the authors succinctly cover what is known about the causes of maltreatment, the efficacy of present societal responses to the problem, and the developmental sequelae of abuse and neglect. The reader learns that maltreated children may suffer permanent damage, and of the difficulties of determining the extent to which disabilities precede or result from abuse or neglect. Setting the theme for the chapters that follow, the authors describe the complex interaction of biological, familial, and societal variables that contribute to the maltreatment of children with disabilities. Yet virtually no data are cited on the incidence or prevalence of maltreatment among children with disabilities, and none of the contributors attempt to review any of the risk or incidence studies that have been conducted. No original data on the scope of the problem are presented.

1.1.1 Definitions

A central problem in determining the prevalence of maltreatment among children with disabilities is arriving at valid and reliable definitions of disabilities. In their examination of this problem, Schilling and Schinke (1988) found that no nationwide system exists for reporting disabling conditions. School systems, thought to apply sound criteria in determining the need for special classes, apply definitions in ways that suit many social, organizational, legal, and educational needs (Schilling, Schinke, & Kirkham, 1988). Responses to a recently completed survey of State CPS agencies on maltreated children (Westat, Inc., 1991) were more instructive about interstate differences in definitions than they were about the numbers of children with disabilities in the CPS systems. Only three or four State CPS agencies appeared to systematically differentiate cases involving children with disabilities from other cases.

This definitional problem takes on added meaning when child protection practitioners are asked to identify disabilities. In an effort to determine whether or not child protection workers were identifying developmentally disabled children, Schilling, Kirkham and Schinke (1986) conducted a study of 51 child protection workers in two Western States. Eighty percent believed that a disability increases a child's risk of abuse or neglect. Yet only eight workers indicated that they were aware of a disability among the preschool children in their child protection caseloads. This finding is particularly interesting in that 71 percent of the caseworkers judged themselves as at least moderately skilled in determining whether or not a child is developmentally disabled. When asked about the small numbers of children with disabilities reported by child protection workers, supervisors believed either that their staff were not recognizing such children, or that workers were not encountering children with disabilities. A separate factor that may enter here is prevalence (i.e., most maltreated children may not be disabled).

1.1.2 Available Data

Numerous investigators have examined the relationship between maltreatment and disability. Frodi (1981) reviewed studies, with sample sizes ranging from 14 to 6,000, in which children with disabilities were disproportionately represented. Gil's (1970) study of 12,000 children reported that 22 percent of abused children had a physical or intellectual impairment. In one study (Johnson and Morse, 1968), researchers determined that 70 percent of 97 abused children had some form of mental disability. However, as in many of the studies that find such high rates of disability among maltreated populations, the categories were nonspecific, and included minor physical anomalies.

Sangrund, Gaines, and Green (1974) compared the mental status of abused vs. other children. Controlling for socioeconomic status, the investigators found that 25 percent of abused children were mentally retarded whereas only 3 percent of controls were mentally retarded. A study by Souther (1984) found that, among 125 children receiving child protection services in two West Virginia counties, 69 percent had one or more disabilities. However, the definition of disability included emotional disorders, an inclusive category that may not coincide with most definitions of developmental disability. An earlier study of 263 child protection workers in the same State found that, in 35 percent of client children, conditions of maltreatment resulted in disabilities; it also found that, in 37 percent of client children, disabilities were a possible contributing condition to the occurrence of abuse or neglect.

In another study, Diamond and Jaudes (1983) retrospectively reviewed the charts of 86 children and adolescents with cerebral palsy. Nine percent had been maltreated following the diagnosis of cerebral palsy. In an expanded study of 162 children with cerebral palsy (Jaudes and Diamond, 1985), the authors found that 23 percent had been abused, including 9 percent who had developed disabilities as a result of abuse. Sullivan, Brookhouser, Knutson, Scanlan, and Schulte (1991) studied the records of 482 children with disabilities who had experienced maltreatment and were evaluated at a national research hospital over a 4-year period. The most frequent type of maltreatment was sexual abuse, for both male and female children (43 percent and 55 percent, respectively), and across types of disabilities.

Robert Ammerman has been perhaps the most prolific contributor to the knowledge base on maltreatment of children with disabilities (e.g., Ammerman, Lubetsky, and Drudy, 1990). In one study (Ammerman, Van Hasselt, Hersen, McGonigle, and Lubetsky, 1989), the charts of psychiatrically hospitalized children with multiple disabilities were examined for past evidence of maltreatment. Disabilities included seizure disorders, sensory disabilities, cerebral palsy, spina bifida, and mental retardation; psychiatric diagnoses included organic brain syndrome and pervasive developmental disorder. The researchers believed that the high levels of behavioral dysfunction exhibited by these children would place them at extreme risk of abuse and neglect.

In the Ammerman et al. (1989) study sample of 150 children, 19 percent exhibited definite evidence of abuse or neglect, 9 percent received a probable rating, and 11 percent contained possible evidence of maltreatment. In analyzing records on 42 children whose maltreatment was coded as definite or probable, physical abuse was present for 69 percent of the children, neglect for 45 percent, and sexual abuse for 39 percent of the children (allowing for multiple forms of maltreatment for any one child). In comparisons with nonmaltreated patients, maltreated children were more likely to live in settings other than with their natural parents. In most instances, the maltreatment was the event that resulted in a protective placement. Although no differences were found for child's age, race, disability, or number of psychiatric hospitalizations, maltreated children tended to have more siblings. Several associations between type of maltreatment and disability emerged.

Several other studies reported either low (4 percent) rates of children with disabilities among maltreated children (Iowa Department of Social Services, 1977), or no differences in rates of disability across abused and non-abused populations (Starr, 1982). For example, Benedict, White, Wulff, and Hall (1990) examined records for information on child maltreatment for 500 children (i.e., age 12 and under) with multiple disabilities that included moderate to profound retardation for over 97 percent of the children. These children were assessed or treated, over an 11-year period, by a program that specializes in children with disabilities. Finding that less than 11 percent of the children had experienced maltreatment that was substantiated by a social service agency, the authors concluded that their data do not confirm any increased risk of substantiated maltreatment for this population. In explaining the disparate findings, Ammerman, Van Hasselt, and Hersen (1988) have observed that the studies often fail to define disability, ask professionals with little training to make judgments about disabilities, or may fail to substantiate abuse when children have communication deficits.

1.1.3 Comparison With General Populations

By way of comparison, findings on physical and sexual abuse gathered in surveys of general populations should be noted. The 1985 National Family Violence Survey (Strauss and Gelles, 1988) found that *annual* incidence rates of severe violence directed by parents toward children 0-17 was 110 per 1,000. Of adult women polled in San Francisco, 28 percent reported that they had experienced unwanted sexual touching or other forms of abuse before age 14 (Russell, 1984). Proportions of male and female adults reporting earlier sexual abuse were 3 percent and 12 percent in Texas (Kercher, 1980), and 6 percent and 15 percent in Boston (Finkelhor, 1984). Hence, given that physical and sexual abuse over the childhood period may have high prevalence, reports of high rates of maltreatment among children with disabilities must be viewed in terms of overall maltreatment prevalence.

1.1.4 Institutional Maltreatment

Also of concern are developmentally disabled children and adults in institutional settings. In an effort to determine the extent to which States are monitoring institutional maltreatment, Zuckerman, Abrams, and Nuehring (1986) conducted a survey of directors of 52

State Protection and Advocacy organizations. Operating in 50 States, Puerto Rico, and the District of Columbia, these organizations have the authority to pursue legal and administrative remedies to protect the rights of persons with disabilities. Of the 43 protection and advocacy agencies responding, 63 percent reported that they investigated organizational patterns of maltreatment, and 26 percent indicated that they did not carry out this function. With respect to investigations of individual reports of allegations of abuse and neglect of a specific resident, 19 percent did none, 19 percent did independent investigations, 19 percent did joint investigations with other government agencies or advocacy groups, and 44 percent conducted both independent and collaborative investigations.

More than half of the protection and advocacy agencies had no access to client records unless a specific client or interested party requested assistance. Often, protection and advocacy agencies were dependent upon the very organizations they were investigating for access to data. On average, most agencies devoted less than one full-time equivalent to investigating maltreatment in residential agencies. For all of these reasons, no valid database on maltreatment in institutions exists for developmentally disabled persons.

The child welfare system, beyond protection and advocacy agencies, also serves many children with disabilities who may be maltreated. Unfortunately, capturing how many children with disabilities are served by this system is very difficult (Camblin, 1982; Richardson, West, Day, and Stuart, 1989). A survey by Richardson et al. of child welfare and developmental disabilities/mental retardation directors found that interagency cooperation was generally poor. Although only superficial data are reported, child welfare organizations and developmental disability organizations appear to have had little understanding of the services provided by one another. Given these findings, the scarcity of State data, in either child welfare or developmental bureaus, on the prevalence of maltreated children with disabilities or on the extent of maltreatment in child welfare institutions is not surprising (Rindfleisch & Rabb, 1984).

1.1.5 Conclusions

In sum, many studies, most quite modest, attempt to show that among maltreated children, disabilities are overrepresented. A smaller number of studies have examined children with disabilities, finding that such children are more likely than children without disabilities to be abused or neglected. Unfortunately, most studies have methodological limitations and invite criticism. Because no prospective investigations have been conducted, questions of cause and effect remain unanswered. Absent are well designed and conducted studies in which maltreatment and disability are carefully defined and reliably determined.

1.2 Methodology

In this section, definitions of key terms are presented. The section also describes the methodology used to assemble the findings for this report and highlights the strengths and limitations of the methodology.

1.2.1 Definitions

In the remainder of this report, several terms are used repeatedly that may be unfamiliar to the reader. These terms are as follows:

- **Substantiated Case of Child Maltreatment** - This refers to one or more children, usually in a family, for whom a CPS agency investigation has indicated that child maltreatment occurred. The definition may encompass the terms for investigation dispositions that are used by some agencies, such as confirmed, founded, and indicated. The definition of child maltreatment varies among CPS agencies.
- **Disability** - Children were considered to have a disability if two criteria were met: (a) they were suspected of being mentally retarded, hard of hearing, deaf, speech impaired, visually impaired, blind, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, or of having specific learning disabilities or multiple disabilities; and (b) who, because of those impairments, had limited functioning in one or more life activities, including mobility, self-care, receptive and expressive language, learning, self-direction, capacity for independent living, and economic self-sufficiency. (This terminology and this definition are similar to those used by other organizations such as the U.S. Department of Education.)
- **Perinatally At-Risk Condition** - Children were considered to have a perinatally at-risk condition if they were under one year of age and they were suspected of being low birth weight, premature, or HIV infected, or of having a positive drug or alcohol toxicology.

Appendix C is a glossary that contains additional definitions.

1.2.2 Data Collection

Beginning in October 1989, the study involved 2 rounds of data collection conducted with caseworkers in a nationally representative sample of 35 Child Protective Services (CPS) agencies. (See Figure 1-1.) The first round (Data Collection #1), which provided much of the information for this report, ran for 4 or 6 weeks. All cases of maltreatment that were investigated and substantiated by a sampled CPS agency during that period became a part of data collection efforts. The instrument for Data Collection #1 focused on information that allowed the Director of NCCAN to form preliminary estimates of the incidence rates of child maltreatment among children with disabilities. CPS caseworkers used this instrument to provide information on each of 1,249 substantiated cases of maltreatment involving 1,834 maltreated children. To develop incidence estimates, information from Data Collection #1 was combined with information from previously conducted studies on child maltreatment and disabilities in the general population. These secondary sources included the Study of the National Incidence and Prevalence of Maltreatment (NIS-2), and data from the U.S. Department of Education on the participation of children in Federally funded programs for children with disabilities.

A subsequent round of data collection, Data Collection #2, involved conducting telephone interviews with the current or last caseworker assigned to the cases identified in the first round. Data Collection #2 occurred approximately 90 days after a case was substantiated. This data collection effort focused on collecting additional information on services received and on case outcomes. It also confirmed the estimates from Data Collection #1 on disabilities. (The estimates of some disabilities may change to a limited extent as additional information is gained after investigations are completed.) Following Data Collection #2, data on the status of cases (e.g., open or closed) were collected periodically from the CPS agencies in the study.

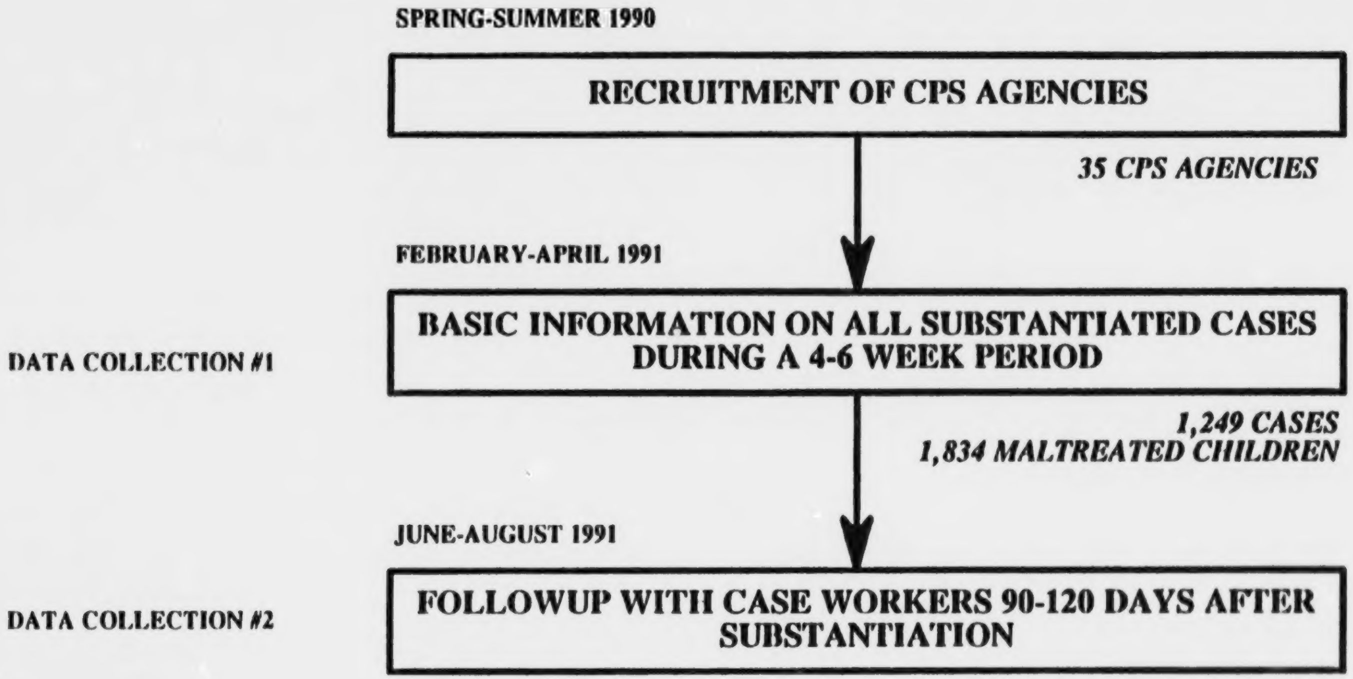
SPRING-SUMMER 1990
RECRUITMENT OF CPS AGENCIES
35 CPS AGENCIES
FEBRUARY-APRIL 1991
DATA COLLECTION #1
BASIC INFORMATION ON ALL SUBSTANTIATED CASES DURING A 4-6 WEEK PERIOD
1,249 CASES
1,834 MALTREATED CHILDREN
JUNE-AUGUST 1991
DATA COLLECTION #2
FOLLOWUP WITH CASE WORKERS 90-120 DAYS AFTER SUBSTANTIATION

Figure 1-1. Flow of data collection

1.2.3 Strengths and Limitations of Methodology

One of the strengths of the study was that it collected information from those in the best overall position to have information on the maltreatment of children and their characteristics: caseworkers in CPS agencies. Because these caseworkers were service brokers, they were also the best source of information on services provided to children and families and on case outcomes. Additional strengths of the study were its longitudinal design and prospective data collection. This design permitted following cases for up to 4 months to better understand how service delivery decisions were made and how these decisions influenced case outcomes. Collecting data prospectively, directly from caseworkers, yielded more complete and reliable information than would have been possible collecting data retrospectively and relying on case records.

A limitation of the study was that it relied on "suspected" assessments of disabilities by caseworkers in CPS agencies. These assessments are not as sure as those of health care professionals in disability diagnosis. The caseworkers are not qualified to diagnose disabilities. They are service brokers for the children whose maltreatment was substantiated and their families and, as such, they had the best information available on maltreatment status, services provided, and case outcomes. Also, some of the analyses were based on caseworkers' unconfirmed perceptions of whether or not children's disabilities led to or contributed to maltreatment and maltreatment caused disabilities. The extent to which these limitations influence study results is unknown. Nevertheless, the caseworker is the best source of information on the disabilities of children in maltreatment cases.

The study has three other limitations that may affect the generalizability of its results. First, many of the CPS agencies serve only children who are within family settings. Children in institutional settings (e.g., day care centers and public facilities for children with disabilities) were excluded from the investigations and caseloads of some of the CPS agencies. Second, data were collected only for cases of maltreatment that were substantiated during the late winter and early spring of 1991. The methodology did not account for seasonal variation, if any, in the occurrence and reporting of maltreatment and disabilities. Third, this study included only cases of maltreatment that were reported to CPS agencies.

2. THE INCIDENCE OF MALTREATMENT AMONG CHILDREN WITH DISABILITIES

Children with disabilities were over-represented among children whose maltreatment was substantiated by a CPS agency. When analyzed with other information, this study finding indicates that children with disabilities were at greater risk of experiencing maltreatment than children without disabilities. This and other findings on the incidence of maltreatment (i.e., number or rate of cases of maltreatment that start up anew in a given time period) among children with disabilities are discussed in the current chapter.

2.1 Rates of Disabilities Among Children Whose Maltreatment Was Substantiated

To estimate the rates of disabilities among children whose maltreatment was substantiated, caseworkers were asked to identify children who had suspected or known disabilities. As mentioned, this identification could have been based on information from sources that can properly diagnose such conditions or on sources that were not qualified to diagnose disabilities. Before deciding to use this approach, several alternative approaches were considered and rejected. For example, reviewing CPS case files was deemed to be faulty because such files often do not contain information on children's disabilities; and professional assessments of children in maltreatment cases were infeasible and too expensive. Although relying on caseworker suspicions and knowledge to identify children with disabilities is imperfect, it was the strongest and most feasible of the approaches considered.

For an estimated 14.1 percent of children whose maltreatment was substantiated by CPS, CPS caseworkers suspected one or more disabilities. The rates of disabilities among maltreated children observed in the study were compared with rates of disabilities for children in the general population. (See Table 2-1.) For the comparison, a rate of 9 percent was used. Estimates of the proportion of children ages 0-17 in the United States who have disabilities range from 7 to 10 percent. For example, the U.S. Department of Education served slightly under 7 percent of all children aged 0-17 under Chapter 1 of the Elementary and Secondary Education Act and Part B of the Individuals with Disabilities Education Act; slightly under 10

Table 2-1. **Percent of maltreated children with disabilities and ratio of maltreated children with disabilities to children with disabilities in the general population, by type of maltreatment**

Type of maltreatment	1 Percent of children with specific type of maltreatment with disabilities[a] (standard error)	2 Ratio of percent of children with specific type of maltreatment with disabilities to percent of children in general population with disabilities (9.0%)[b]
Any maltreatment	14.1 (1.9)	1.57**
Physical abuse	17.2 (3.8)	1.91**
Sexual abuse	15.2 (3.9)	1.69*
Emotional abuse	10.6 (3.6)	1.18
Physical neglect	13.7 (3.4)	1.52*
Educational neglect	18.0 (11.6)	2.00
Emotional neglect	21.3 (9.5)	2.37*

[a] Estimates are from this study. The percent of children with a specific type of maltreatment with disabilities is the ratio of the number of children with a specific type of maltreatment with disabilities to the total number of children with that specific type of maltreatment.

[b] The estimated percent of children with disabilities who are under 18 years old in the United States is 9.0 percent. This estimate is based on the number of children served under Chapter 1 of the Elementary and Secondary Education Act and Part B of the Individuals with Disabilities Education Act (U.S. Department of Education, 1991).

*The ratio is statistically greater than 1.0 for one-tailed test of signficance at & = 0.10.

**The ratio is statistically greater than 1.0 for one-tailed test of significance at & = 0.05.

percent of children aged 6-17 were served (U.S. Department of Education, 1991). The study assumed that younger children who have disabilities are less likely to be served by the Act and that roughly 9 percent of all children between the ages of 0 and 17 have disabilities.

The rate of disabilities among children whose maltreatment was substantiated was 1.6 times higher than disabilities among children in the general population. Physically abused children were significantly ($p < 0.05$) more likely to have disabilities than children in the general population. Disabilities were also more likely for children who experienced sexual abuse, physical abuse, and emotional neglect than for children in the general population, but the level of certainty was lower for these findings ($p < 0.10$).

The observed rate of disabilities may be slightly underestimated. In Data Collection #2, suspected disabilities among maltreated children prior to the maltreatment were confirmed. This effort resulted in a net gain in the number of maltreated children with disabilities and in a small increase in the estimated rate of disabilities. However, Data Collection #2 permitted the confirmation of disabilities for most, but not all, maltreated children. To the extent that information changed on the disabilities of maltreated children who were excluded from Data Collection #2, the revised rates of disabilities are slightly underestimated.

2.2 Rates of Maltreatment Among Children With Disabilities

Maltreated children with disabilities are 1.7 times more likely to experience at least one occurrence of maltreatment than children without disabilities. This estimate is based on data from the Study of the National Incidence and Prevalence of Child Maltreatment (NIS-2), which derived an estimate of the annual incidence of child maltreatment (Westat, Inc., 1988). (See Table 2-2.)

To derive estimates of the annual rate of maltreatment among children with disabilities, maltreatment rates from NIS-2 were combined with the current study's observations on rates of disabilities. Combining data from these two different sources is reasonable because both approaches are nationally representative. However, combining the data required one key assumption: **The proportion of maltreated children who have disabilities was the same among**

Table 2-2. Incidence of child maltreatment: overall and by whether or not children have disabilities

	1	2	3	4
Type of maltreatment	Incidence for all children (per 1,000)[a]	Incidence for all children with disabilities (per 1,000)[b]	Incidence for all children without disabilities (per 1,000)[c]	Ratio of incidence for all children with disabilities to incidence for all children without disabilities (column 2 ÷ column 3)
Any maltreatment	22.6	35.5	21.3	1.67
Physical abuse	4.9	9.4	4.5	2.09
Sexual abuse	2.1	3.5	2.0	1.75
Emotional abuse	3.0	3.5	2.9	1.21
Physical neglect	8.1	12.3	7.7	1.60
Educational neglect	4.5	9.0	4.1	2.20
Emotional neglect	3.2	7.6	2.8	2.77

[a] Estimates are from the Study of the National Incidence and Prevalence of Child Maltreatment (NIS-2).

[b] Estimates were derived by multiplying column 1 by the ratio of percent of children with a specific type of maltreatment with disabilities to percent of children in the general population with disabilities. (See Table 2-1.)

[c] Estimates in this column were derived by disaggregating the estimates in column 1, given the estimates in column 2.

cases substantiated by CPS as it was among cases unknown to CPS. While the validity of this assumption cannot be assessed directly with data from the current study or NIS-2, a model was developed to test the assumption indirectly. (See Section A.1.6.) This model separately correlated disabilities with information on children's demographic characteristics that was collected in the current study and NIS-2 and predicted disabilities for the cases unknown to CPS, based on the characteristics of this population as observed by NIS-2. The results of the modeling effort suggested that the study may slightly underestimate the rate of disabilities among maltreated children. However, no adjustment was made to the estimated rate because the underestimate was small relative to the variability of the estimates.

National estimates of the incidence of maltreatment for children with disabilities and for children without disabilities were derived from the current study results and external data. (See Table 2-2.) For example, given that 22.6 per 1,000 children were maltreated in a year (from NIS-2) and that a child whose maltreatment was CPS substantiated was 1.57 times as likely as a child in the general population to have disabilities (from the current study), then 22.6 times 1.57, or 35.5, of every 1,000 children with disabilities were estimated to be maltreated annually. Further, 9 percent of children in the general population have disabilities. Hence, the incidence of 21.3 per 1,000 children without disabilities was derived. Children with disabilities were approximately 1.67 times more likely to be maltreated than were children without disabilities (35.5 per 1,000 divided by 21.3 per 1,000). In the estimates presented in column 4 of Table 2-2, the incidence of maltreatment is higher for children with disabilities for all six different types of maltreatment.

3. MALTREATED CHILDREN WITH DISABILITIES: CHARACTERISTICS OF CHILDREN, ADULTS, AND CASE PROCESSING

Among children whose maltreatment had been substantiated by a CPS agency, children with disabilities differed from children without disabilities on demographic characteristics and on the type of maltreatment that they experienced. Caseworkers reported that maltreated children who had injuries related to the maltreatment were at great risk of developing disabilities. CPS agencies appeared to treat maltreated children with disabilities differently from maltreated children without disabilities. The number of children whose maltreatment was substantiated by the nationally representative sample of 35 CPS agencies in the study during the 6-week data collection period represents approximately 887,000 (plus or minus 276,000) children in the United States whose maltreatment was substantiated anew by a CPS agency during calendar year 1991. Some of these children were previously reported to and their maltreatment was substantiated by a CPS agency. This chapter presents findings on maltreated children with disabilities, on the maltreatment that they experienced, on the characteristics of adults associated with these cases, and on CPS agency processing of cases for maltreated children with disabilities.

3.1 Characteristics of Children Whose Maltreatment Was Substantiated

In this section, study results are presented on the disabilities of children whose maltreatment was substantiated and on the demographic characteristics of children with disabilities and children without disabilities whose maltreatment was substantiated. Results are also provided on the relationship between disabilities and child maltreatment. The characteristics of the maltreated children in the study are summarized in Table 3-1; Section 3.1.2 highlights differences between children with and without disabilities on these characteristics.

3.1.1 Disabilities

Children with disabilities accounted for 14.1 percent of the children whose maltreatment was substantiated by a CPS agency. Figure 3-1 provides the rate of each "primary type of disability" identified by caseworkers. (The primary type of disability is the one type of

Table 3-1. Characteristics of all maltreated children and of maltreated children with and without disabilities identified nationally during study period

Characteristic	All maltreated children identified during study period		Maltreated children with disabilities identified during study period		Maltreated children without disabilities identified during study period	
	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample
Disability						
Yes	14.1	234				
No	85.9	1,600				
	100	1,834				
Race/ethnicity						
White, not Hispanic	60.7	769	72.1	119	58.8	650
Black, not Hispanic	28.2	704	20.5	73	29.5	631
Hispanic	8.1	248	5.0	27	8.6	221
Other	2.9	108	-	13	3.0	95
	100	1,829	100	232	100	1,597
Sex						
Male	47.8	908	71.4	148	43.9	760
Female	52.2	925	28.6	85	56.1	840
	100	1,833	100	233	100	1,600
Age						
Under 1 year	10.6	219	7.7	17	11.1	202
1-4	22.6	422	23.3	54	22.5	368
5-9	32.5	548	23.5	70	34.0	478
10-13	19.5	368	21.1	46	19.2	322
14-17	14.8	231	24.4	40	13.2	191
	100	1,788	100	227	100	1,561
Number of children in family						
1	26.7	509	32.5	79	25.7	430
2	24.7	468	31.2	67	23.6	401
3	26.6	463	20.2	57	27.6	406
4+	22.1	394	16.0	30	23.1	364
	100	1,834	100	233	100	1,601
Type of maltreatment[b]						
Physical abuse[c]	28.3	589	34.6	83	27.2	506
Sexual abuse[c]	20.0	275	21.6	39	19.7	236
Emotional abuse[c]	15.8	226	12.0	29	16.5	197
Physical neglect[c]	27.9	533	20.6	60	29.1	473
Medical neglect[c]	9.9	133	18.8	38	8.4	95
Abandonment	3.2	96	3.3	8	3.2	88
Expulsion/refusal to care	4.0	54	3.9	10	4.0	44
Inadequate supervision	21.2	361	22.0	41	21.0	320
Inattention to special education need	0.9	13	3.4	10	-	3
Other educational neglect	4.4	41	-	5	4.7	36
Inadequate nurturance	2.6	52	5.0	17	2.3	35
Refusal or delay of psychological care	-	14	-	5	-	9
Other emotional neglect	1.5	33	-	3	1.6	30
Other maltreatment	0.6	23	-	2	0.1	21
Positive drug or alcohol toxicology	2.6	82	-	2	3.0	80

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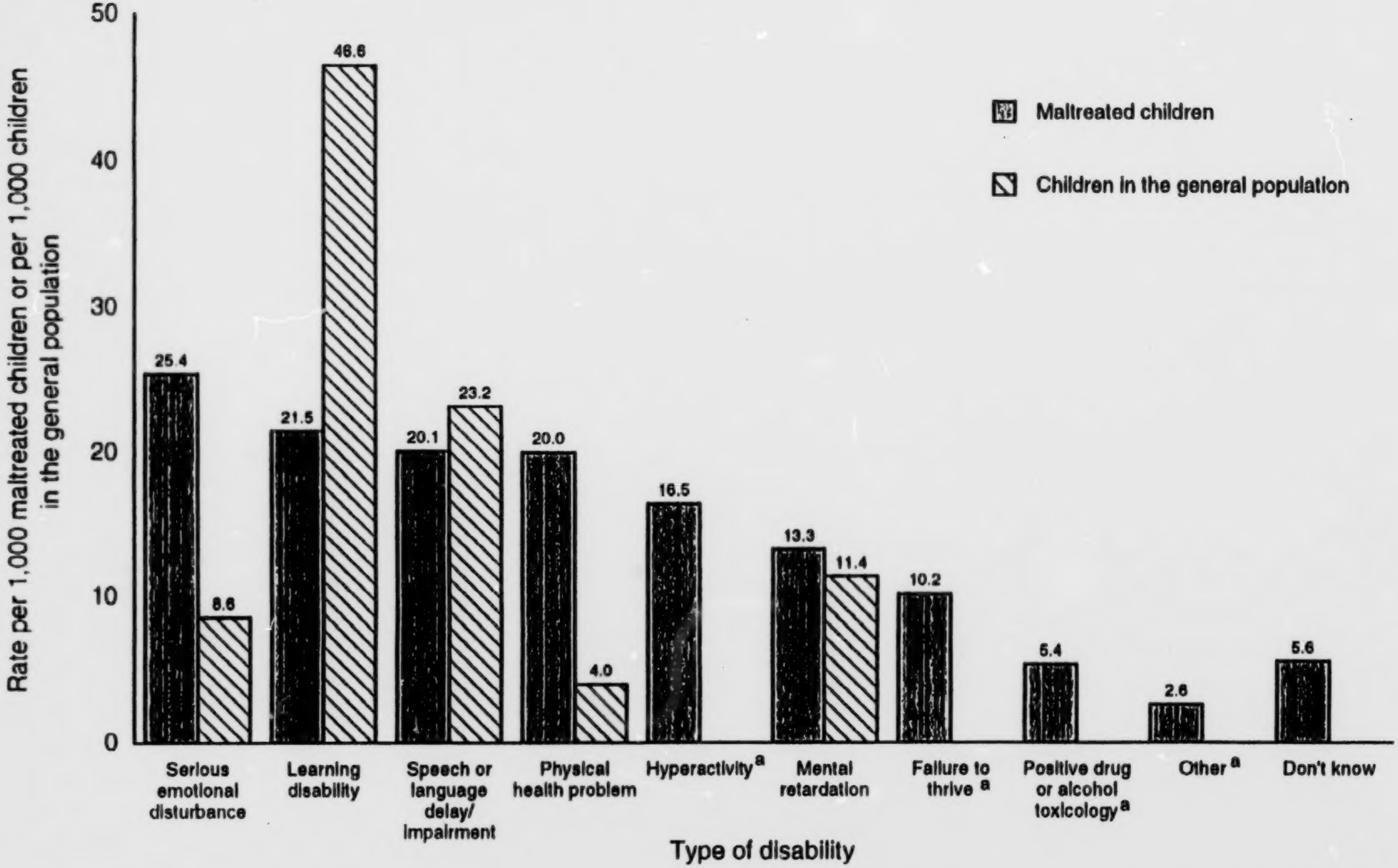
[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. A dash indicates that the estimated national number is less than 500.

[b] Column totals for percent and number exceed 100 percent and the total number of maltreated children, respectively, because a child may have experienced more than one type of maltreatment.

[c] A two-tailed test of the statistical significance of the difference between maltreated children with disabilities and those without disabilities on percent with this type of maltreatment was conducted. It revealed no statistically significant difference at & = 0.05.

Figure 3-1. Estimated rate of maltreated children with disabilities (per 1,000 maltreated children) and of children in the general population with disabilities (per 1,000 children in the general population) by primary type of disability



Note: The number of children in the study sample of maltreated children was 1,834. The estimates for children in the general population with disabilities are based on the number of children, 6 to 17 years old, served under Chapter 1 of the Elementary and Secondary Education Act and Part B of the Individuals with Disabilities Act (U.S. Department of Education, 1991).

[a] The U.S. Department of Education (1991) did not report on these types of disability and conditions.

disability that the caseworker considered to be the most serious problem for a child with disabilities.) This figure also indicates the rate of each primary disability for children 6 to 17 years old in the general population (U.S. Department of Education, 1991). As shown, the most frequently found conditions for maltreated children were serious emotional disturbance (25.4 per 1,000 maltreated children) and learning disability (21.5 per 1,000 maltreated children). The rate of maltreated children with physical health problems (i.e., physical disabilities and serious illness) was 20.0 per 1,000 maltreated children. Compared to children in the general population, maltreated children experienced: a lower rate of learning disability; similar rates of speech or language delay/impairment, and of mental retardation; and higher rates of serious emotional disturbance and of physical health problems.

In addition to those children with disabilities, children under the age of 1 who were born premature, with a low birthweight, having a positive drug or alcohol toxicology, or testing positive for the HIV virus were identified as being "perinatally at-risk" (i.e., at risk for developing a disability). These children accounted for about 1.3 percent of all maltreated children. Within this group, 57.9 percent had a positive drug or alcohol toxicology as the primary risk factor, 32.3 percent were premature, 3.9 percent were low birthweight, and 5.9 percent tested positive for the HIV virus. The at-risk children may develop into children with disabilities later but, below age 1, diagnoses of disabilities are rarely reported outside of physical disabilities.

Despite the widespread perception that the number of foster care cases is being driven by substance abuse by pregnant women, the nationally representative sample of 35 CPS agencies studied shows less than 2.6 percent, or 26 per 1,000 children, whose maltreatment was substantiated, experienced positive drug or alcohol toxicology as a type of maltreatment. (See Table 3-1.) This study also indicates that less than 7 per 1,000 children whose maltreatment was substantiated have positive drug or alcohol toxicology as a primary at-risk condition.

Because only 41 perinatally at-risk children are in the sample, inference about this population is extremely limited and should be viewed with caution. Similarly, the small number of cases of most types of disabilities precludes extensive analysis by primary type of disability. Some data are presented for perinatally at-risk children and for each type of disability for the purpose of clarifying certain key findings, where appropriate.

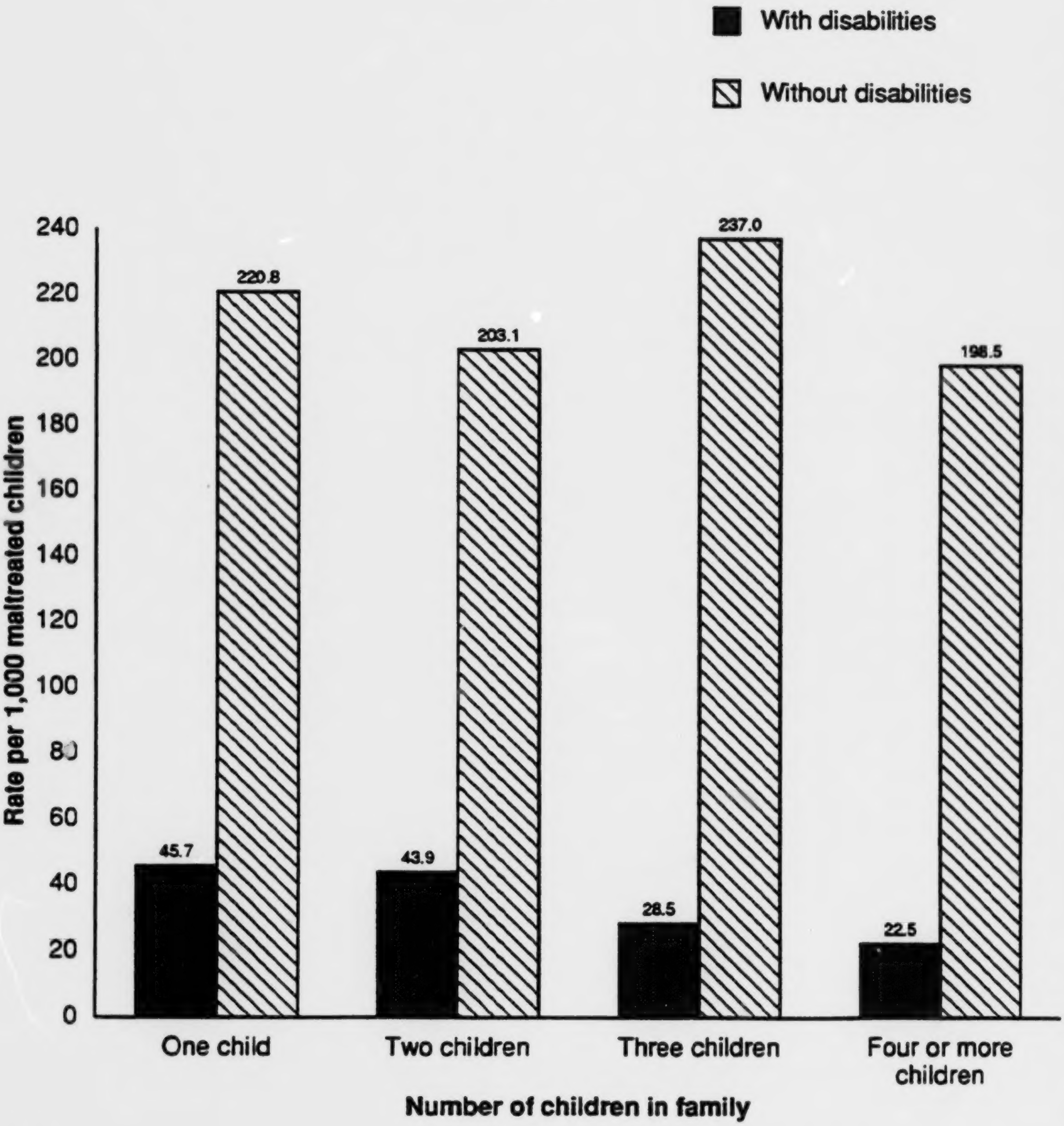
3.1.2 Demographic Characteristics

Among children whose maltreatment was substantiated, children with disabilities differed from children without disabilities on several demographic characteristics. As shown in Figure 3-2, maltreated children with disabilities were more likely to come from one-child families than from families with multiple children; maltreated children without disabilities were more likely to come from three-child families. The mean age for children with disabilities in the study was 8.6 years compared to 7.7 years for children without disabilities. The difference in age distribution was greatest for children 5-9 and 14-17 years old. (See Table 3-2.) Fewer than 24 percent of children with disabilities in the study were 5-9 years old compared to 34.0 percent of children without disabilities. About 24 percent of the children with disabilities were age 14-17 compared to only 13.2 percent of those who were without disabilities. The difference in ages among children with disabilities and children without disabilities in the study may have been related to the age at which a disability is noted or diagnosed, or it may have been related to the source of referral for maltreated children. As subsequently described, children with disabilities in the study were more likely to be referred for maltreatment by the schools than were children without disabilities.

Children with disabilities and children without disabilities in the study also differed by sex and race/ethnicity. Although maltreatment was found almost equally among male and female children, males were more than twice as likely to have disabilities than females. (See Figure 3-3.) This finding is consistent with the literature that indicates males in the general population are more likely to have disabilities than females in the general population (Hermon, Contrucci, and Stockton, 1992; SRI International, 1991). Maltreated White children were more likely to be classified as having disabilities: They accounted for 60.7 percent of all maltreated children as opposed to 72.1 percent of the maltreated children with disabilities. Conversely, maltreated Black and Hispanic children were somewhat less likely to be classified as having disabilities. As shown in Figure 3-4, the rates of disabilities among White, Black and Hispanic maltreated children were 101.3 per 1,000 maltreated children (16.7 percent of all White maltreated children), 28.9 per 1,000 maltreated children (10.2 percent of all Black maltreated children), and 7.1 per 1,000 maltreated children (8.8 percent of all Hispanic maltreated children), respectively.

Problems in diagnosis as well as in the reporting of disabilities complicate efforts to differentiate true differences among the racial/ethnic populations from those that are anomalies of reporting systems. National data do not identify the prevalence of children with disabilities by race/ethnicity. Hence, whether or not the differences found in the maltreated population reflect those

Figure 3-2. Estimated rate of maltreated children with and without disabilities (per 1,000 maltreated children) by number of children in family



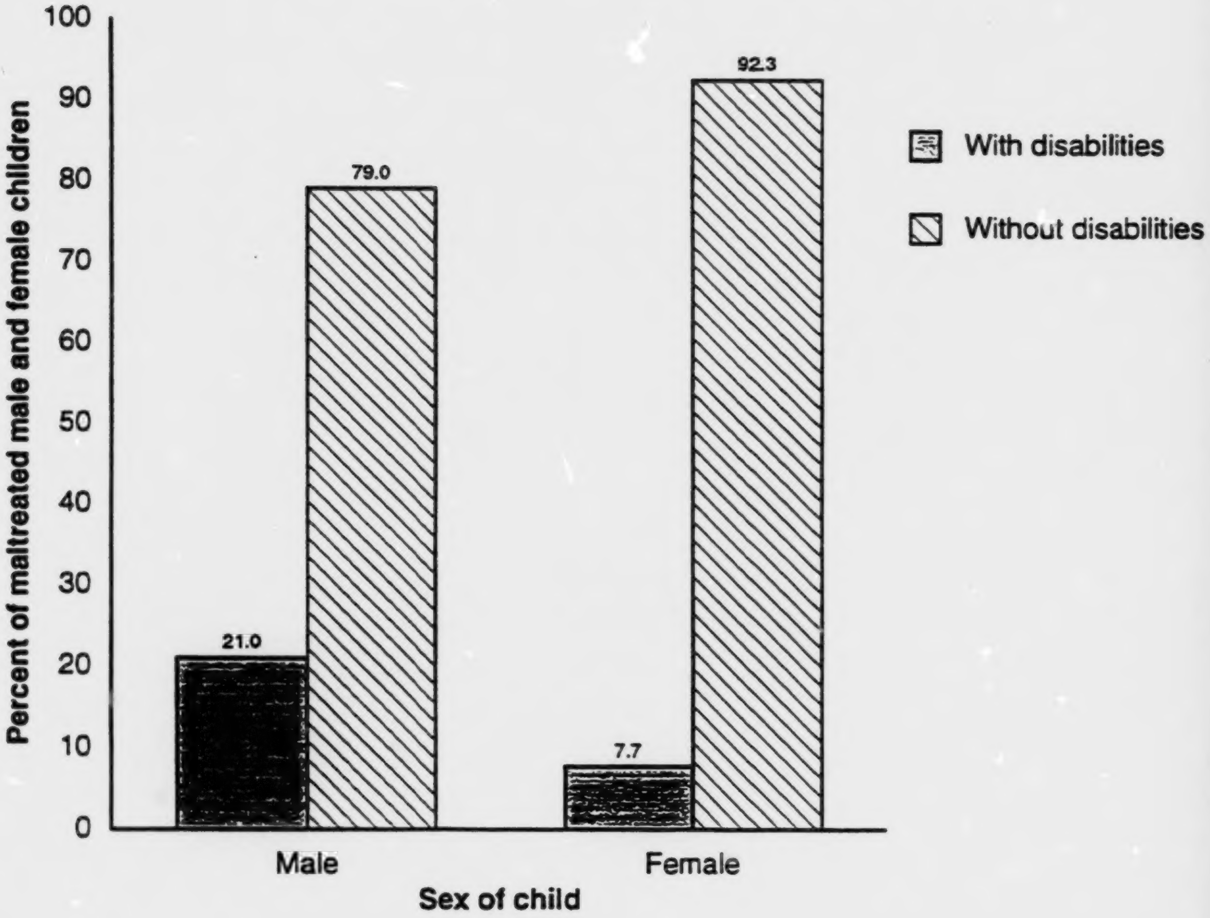
Note: The number of children in the study sample of maltreated children was 1,834.

Table 3-2. Estimated average rate of maltreated children with and without disabilities (per 1,000 maltreated children) per year of age by age category

Age category	Estimated average rate of maltreated children with disabilities (per 1,000 maltreated children) per year of age (column %)	Estimated average rate of maltreated children without disabilities (per 1,000 maltreated children) per year of age (column %)
Under 1 year	10.8 (7.7)	95.1 (11.1)
1-4	8.2 (23.3)	48.4 (22.5)
5-9	6.6 (23.5)	58.4 (34.0)
10-13	7.4 (21.1)	41.3 (19.2)
14-17	8.6 (24.4)	28.4 (13.2)
Total	7.8 (100.0)	47.8 (100.0)

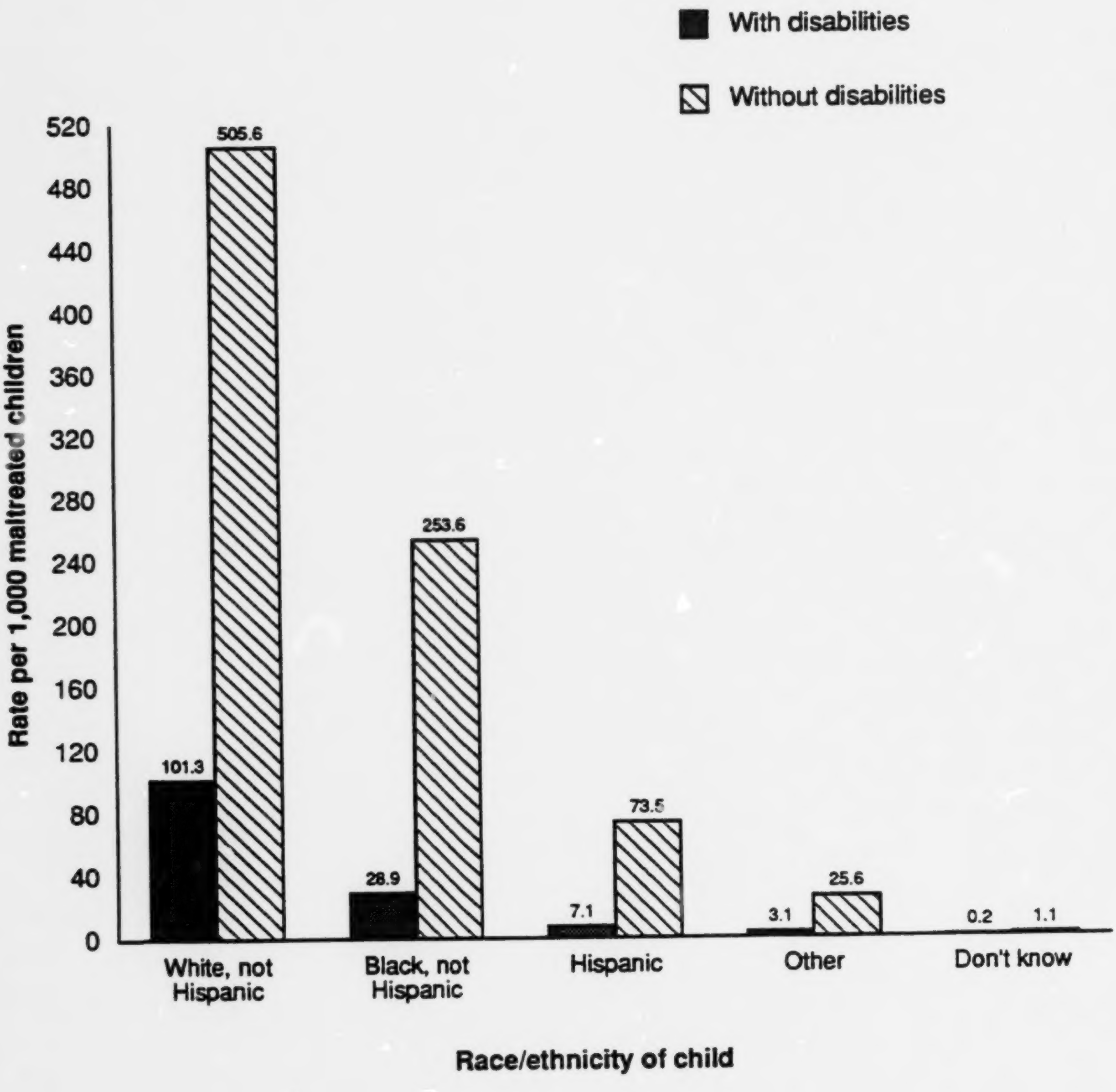
Note: The number of children in the study sample of maltreated children was 1,788. The estimated average rates of maltreated children per year of age were calculated by dividing the estimated rate of maltreated children for an age category by the number of years encompassed by that category.

Figure 3-3. Percent of male and female maltreated children with and without disabilities



Note: The number of children in the study sample of maltreated male children was 908; the number of children in the study sample of maltreated female children was 925.

Figure 3-4. Estimated rate of maltreated children with and without disabilities (per 1,000 maltreated children) by race/ethnicity



Note: The rates are per 1,000 maltreated children overall; they are not per 1,000 maltreated children in specific race /ethnicity groups. The number of children in the study sample of maltreated children was 1,829.

found in the general population cannot be assessed. These problems, coupled with the small number of cases of children with disabilities in the study, made interpretation of the data difficult. Nevertheless, these findings can help to identify the need for further study.

Analyses were also conducted on the race/ethnicity of maltreated children who were classified as perinatally at-risk (e.g., children under the age of one year who were born premature, with a low birthweight, having a positive drug or alcohol toxicology, or testing positive for the HIV virus). For very young children, maltreated Black children were more likely to be classified as being perinatally at-risk than maltreated White children. The recent widespread use of crack/cocaine and the appearance of the HIV virus may mean that the long-term effects of these conditions on children cannot yet be seen. If Black children are disproportionately testing positive for drugs or alcohol and the HIV virus now, a higher percentage of children with disabilities may be Black in future years. The small number of perinatally at-risk children did not warrant analysis by both race/ethnicity and type of at-risk condition.

In summary, CPS-substantiated maltreated children with disabilities differed from maltreated children without disabilities in several ways. Children with disabilities were disproportionately male, White, older, and from families with only one child in residence.

3.1.3 Disabilities and Type of Child Maltreatment

Among children whose maltreatment was substantiated, children with disabilities differed from children without disabilities on the various types of maltreatment. (Although associations between a child's disabilities and specific types of maltreatment appear to exist, analyses revealed that these associations are not statistically significant.) As shown in Table 3-3, children with disabilities in the study were somewhat less likely to have experienced physical neglect or emotional abuse than children without disabilities. (While Table 2-2 provides information on the percent of children with a given type of maltreatment who had disabilities, Table 3-3 provides information on the percent of maltreated children with and without disabilities who experienced a given type of maltreatment.) Children with disabilities in the study were more likely to be medically neglected than children without disabilities (18.8 percent vs. 8.4 percent). This finding may indicate that, because children with disabilities often have medical needs that require more attention than the needs of children without disabilities, the likelihood of medical neglect may be higher for children with disabilities. They were also more likely to be physically abused. Although children with disabilities were more vulnerable to

Table 3-3. Maltreated children with and without disabilities by type of maltreatment

	Maltreated children *with* disabilities			Maltreated children *without* disabilities		
Type of maltreatment	Estimated rate (per 1,000 maltreated children)	Weighted percent[a]	Number in sample	Estimated rate (per 1,000 maltreated children)	Weighted percent[a]	Number in sample
Physical abuse[b]	48.6	34.6	83	234.1	27.2	506
Sexual abuse[b]	30.3	21.6	39	169.5	19.7	236
Emotional abuse[b]	16.8	12.0	29	141.5	16.5	197
Physical neglect[b]	29.0	20.6	60	250.4	29.1	473
Medical neglect[b]	26.5	18.8	38	72.6	8.4	95
Abandonment	4.7	3.3	8	27.8	3.2	88
Expulsion/refusal to care	5.5	3.9	10	34.7	4.0	44
Inadequate supervision	30.9	22.0	41	180.6	21.0	320
Inattention to special education need	4.7	3.4	10	-	-	3
Other educational neglect	-	-	5	40.2	4.7	36
Inadequate nurturance	7.1	5.0	17	19.4	2.3	35
Refusal or delay of psychological care	-	-	5	-	-	9
Other emotional neglect	-	-	3	13.9	1.6	30
Other maltreatment	-	-	2	5.4	0.6	21
Positive drug or alcohol toxicology	-	-	2	25.5	3.0	80

Note: Column totals for rates, percents, and numbers exceed the rates for maltreated children with and without disabilities, 100 percent, and the number of maltreated children with and without disabilities, respectively, because a child may have had more than one disability. Estimated rates were calculated by dividing the weighted number of maltreated children with or without disabilities with a given type of maltreatment by the total weighted number of maltreated children and multiplying the result by 1,000. Weighted column percents were calculated by dividing the weighted number of maltreated children with or without disabilities with a given type of maltreatment by the total weighted number of maltreated children with or without disabilities, respectively, and multiplying the result by 100.

[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. A dash indicates that the estimated national number is less than 500.

[b] A two-tailed test of the statistical significance of the difference between maltreated children with disabilities and those without disabilities on percent with this type of maltreatment was conducted. It revealed no statistically significant difference at $\alpha = 0.05$.

inattention to special than children without educational needs disabilities, the two groups were roughly equivalent on the incidence of this type of maltreatment. In comparison with the study of psychiatrically hospitalized children with multiple disabilities conducted by Ammerman et al. (1989), which was described in Section 1.1.2, the current study found lower rates of physical abuse (34.6 percent vs. 69 percent) and sexual abuse (21.6 percent vs. 39 percent) among children with disabilities whose maltreatment had been CPS substantiated.

3.1.4 Disabilities Leading To or Resulting From Child Maltreatment

In Data Collection #2, information was collected from caseworkers on whether or not existing disabilities were perceived to have led to or contributed to the maltreatment of the subject child. (The subject child is the one child in each case identified by the caseworkers as the subject of the substantiated maltreatment report.) Information was also gathered on the extent to which maltreatment was perceived to have "caused" disabilities for subject children who had maltreatment-related injuries. As mentioned, information on the role of disabilities in the maltreatment reflects the opinion of the caseworkers, which may or may not be confirmed by reliable independent sources. Also note that the link between a given type of maltreatment and whether or not it caused disabilities is somewhat tenuous: A child may have experienced more than one type of maltreatment, and the analyses were unable to discern which type of maltreatment caused the child's disabilities.

Caseworkers reported that children's disabilities were perceived to have led to or contributed to maltreatment for over 47 percent of the maltreated subject children with disabilities prior to the maltreatment. (See Table 3-4.) A disability was perceived to have contributed to the maltreatment for over 76.1 percent of the maltreated children whose primary disability was a physical health problem. This also proved true for 66.6 percent of maltreated children with serious emotional disturbances and 59.2 percent of maltreated children who were hyperactive. As shown in Table 3-5, caseworkers reported that disabilities were perceived to have contributed to maltreatment for a large proportion of children who were physically abused (32.1 percent), sexually abused (45.1 percent), emotionally abused (36.7 percent), and neglected (26.1 percent).

Table 3-4. Percent of maltreated children for whom disabilities were suspected by caseworker to have led to maltreatment, by type of disability

Type of disability	Weighted percent of maltreated children for whom disabilities were suspected to have led to maltreatment
Any disability	47.2
Learning disability	32.8
Serious emotional disturbance	66.6
Physical health problem	76.1
Mental retardation	43.4
Hyperactivity	59.2
Speech or language delay/impairment	–
Failure to thrive	–

Note: The number of children in the study sample of maltreated children for whom disabilities were suspected to have led to maltreatment was 52. Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. Information on whether or not disabilities were suspected to have led to maltreatment is from caseworker records and inferences.

Table 3-5. Percent of maltreated children for whom disabilities were suspected by caseworker to have led to maltreatment, by type of maltreatment

Type of maltreatment	Weighted percent of maltreated children for whom disability was suspected to have led to maltreatment	Number in sample
Any maltreatment	33.2	76
Physical abuse	32.1	29
Sexual abuse	45.1	8
Emotional abuse	36.7	10
Neglect	26.1	42

Note: The number of children in the study sample of maltreated children for whom disabilities were suspected to have led to maltreatment was 76. Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. Information on whether or not disabilities were suspected to have led to maltreatment is from caseworker records and inferences. The column total exceeds 100 percent because a child may have experienced more than one type of maltreatment. The number of cases available for this analysis makes comparisons among types of maltreatment difficult.

For a substantial percentage of maltreated subject children who experienced injuries as a result of the maltreatment, caseworkers reported that maltreatment definitely caused or was likely to have caused disabilities (36.6 percent). (See Table 3-6.) According to caseworkers, maltreatment definitely or was likely to have caused a disability for 61.5 percent of the maltreated children with maltreatment-related injuries who experienced sexual abuse, for 48.3 percent of the maltreated children with maltreatment-related injuries who experienced emotional abuse, and for 54.6 percent of the maltreated children with maltreatment-related injuries who experienced neglect.

3.2 Characteristics of Adults Associated With Cases of Maltreatment

Among children whose maltreatment was substantiated by CPS, the relationship of the primary caretaker to the child was very similar for children with disabilities and children without disabilities in the study. (See Table 3-7.) The mother was the primary caretaker for 90 percent of the maltreated children. The mother was the primary caretaker for 85 percent of the perinatally at-risk children.

According to caseworkers, the primary caretaker was the perpetrator for 66.7 percent of the children with disabilities and 63.8 percent of the children without disabilities whose maltreatment was substantiated by CPS. (See Figure 3-5.) However, only 11.8 percent of the caretakers of children without disabilities "permitted maltreatment," whereas 19.2 percent of the primary caretakers of children with disabilities permitted maltreatment. (Permitted maltreatment refers to a primary or other caretaker being present during the maltreatment and knowingly allowing or not attempting to intervene to stop the maltreatment, or having reason to know about the problem or danger but not protecting the child or preventing recurrences.) Hence, primary caretakers of children with disabilities were more likely to be passively involved in the maltreatment than to have played no role whatsoever. The age of primary caretakers was similar for both children with disabilities and children without disabilities from the study.

As shown in Table 3-8, the relationship of the perpetrator to the maltreated child was similar for children with and without disabilities. The biological mother was the perpetrator for the majority of maltreated children. For over 15 percent of children with disabilities and children without disabilities, the biological father was the perpetrator.

Table 3-6. Percent of maltreated children with maltreatment-related injuries by extent to which maltreatment was suspected to have caused disabilities, and type of maltreatment

	Extent to which maltreatment was suspected to have caused disability?	
Type of maltreatment	Definitely yes or likely (row %)	Unlikely or definitely no (row %)
Any maltreatment	36.6	63.4
Physical abuse	15.1	84.9
Sexual abuse	61.5	38.5
Emotional abuse	48.3	51.7
Neglect	54.6	45.4

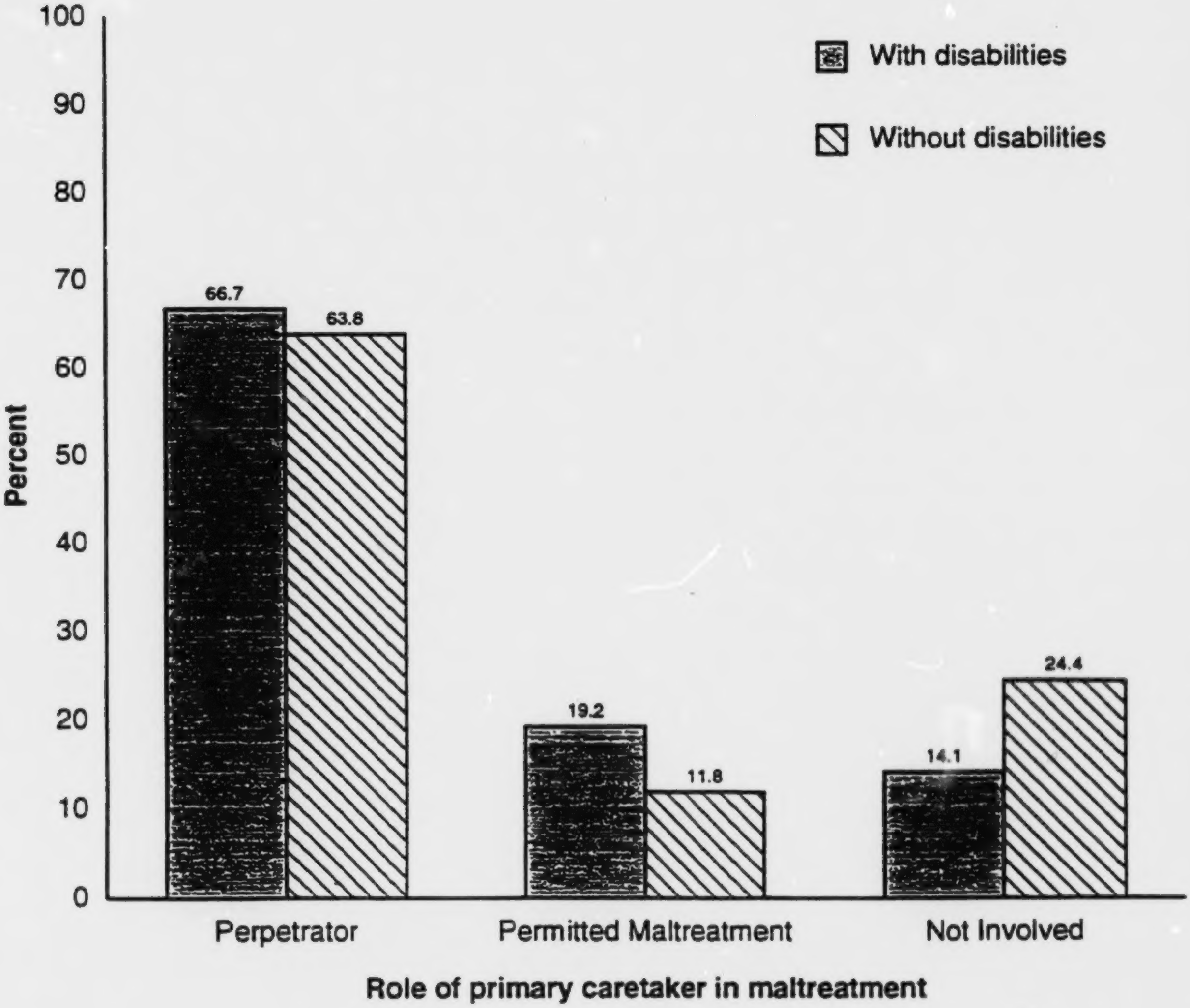
Note: The number of children in the study sample of maltreated children with maltreatment-related injuries was 601. Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. Information on the extent to which maltreatment caused disabilities is from responses by caseworkers to two questions. The first question was, "Was there any injury, even minor, or impairment to [name of the maltreated child] as a result of the maltreatment?" If the response was "yes," the second question was asked: "Has the injury or impairment resulted in any permanent or long-term handicapping condition? The information provided by caseworkers on the extent to which maltreatment caused a disability is based on caseworker records and inferences.

Table 3-7. Percent of maltreated children with and without disabilities by relationship of primary caretaker to child

	Disability			
	Yes		No	
Relationship of primary caretaker	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample
Biological mother	84.5	184	89.6	1,312
Biological father	6.6	13	5.3	52
Adoptive/foster parent, step-parent or other relative	6.2	20	4.5	96
Other	-	1	0.6	8
Don't know	-	1	-	2
Total	100	219	100	1,470

[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. A dash indicates that the estimated national number is less than 500.

Figure 3-5. Percent of maltreated children whose primary caretaker had different roles in maltreatment, with and without disabilities



Note: The number of children in the study sample of maltreated children with disabilities was 255; the number of children in the study sample of maltreated children without disabilities was 1,536.

Table 3-8. Percent of maltreated children with and without disabilities by relationship of perpetrator to child

	Disabilities			
	Yes		No	
Relationship of perpetrator	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample
Biological mother	57.7	132	57.0	938
Biological father	16.5	32	15.4	230
Adoptive/foster parent, step-parent, or other relative	7.7	29	14.5	208
Other	12.2	23	11.6	114
Don't know	5.9	5	1.4	11
Total	100	221	100	1,501

[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used.

In summary, children with disabilities and children without disabilities in the study differed very little on the characteristics of primary caretakers and perpetrators. The most important differences were that primary caretakers of children with disabilities were more likely to permit the maltreatment of a child by another adult and less likely to have been involved in the maltreatment.

3.3 Characteristics of Case Processing

In this section, study results on case processing are discussed. Case processing begins when a CPS agency receives an allegation of maltreatment and proceeds through the investigation of the allegation to the provision of services, if any. Separate subsections are presented on case processing prior to substantiation, at substantiation, and after substantiation.

3.3.1 Case Processing Prior to Substantiation

A substantial proportion of the families of maltreated children with disabilities were known to a CPS agency prior to the substantiated maltreatment. Over 42 percent of the maltreated children with disabilities were in families that had previous allegations of maltreatment recorded. This percentage is very close to that for children without disabilities (39.1 percent).

Schools were the single largest referral source for children with disabilities in the study, accounting for 36.2 percent of all referrals. (See Table 3-9.) In contrast, schools referred only 21.3 percent of all children without disabilities in the study. For children without disabilities in the study, family members, friends, or neighbors were the single largest referral source, comprising 28.0 percent of the referrals. Family, friends, and neighbors referred only 13.8 percent of the children with disabilities. The referral rates from hospitals and physicians, and from mental health, alcohol, or drug treatment programs were very similar for children with disabilities and children without disabilities.

Another way that referral sources for maltreated children were analyzed was to consider which sources could have been expected to have diagnosed or been aware of a disability.

Table 3-9. Percent of maltreated children with and without disabilities by referral source for maltreatment

Referral source	Disabilities			
	Yes		No	
	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample
Law enforcement/criminal justice system	21.6	40	20.5	341
Social service agency	3.5	16	8.3	132
Schools	36.2	83	21.3	334
Hospital, medical	13.8	39	11.3	248
Mental health, drug/alcohol treatment program	-	10	3.6	41
Family member, friend, or neighbor	13.8	28	28.0	385
Other	7.9	16	7.0	118
Don't know	-	1	-	1
Total	100	233	100	1,600

[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. A dash indicates that the estimated national number is less than 500.

Such sources include schools, medical personnel, and mental health, alcohol, and drug abuse treatment centers. From this perspective, 53.0 percent of all referrals of children with disabilities in the study came from sources that could have been expected to have knowledge of the disability. However, the referral source might not have actually diagnosed a child's disabilities. For example, the referral source may have made the referral for a child without disabilities in the family. Also, the referral might be based on information provided by a caretaker of the child, and not on examination of the child.

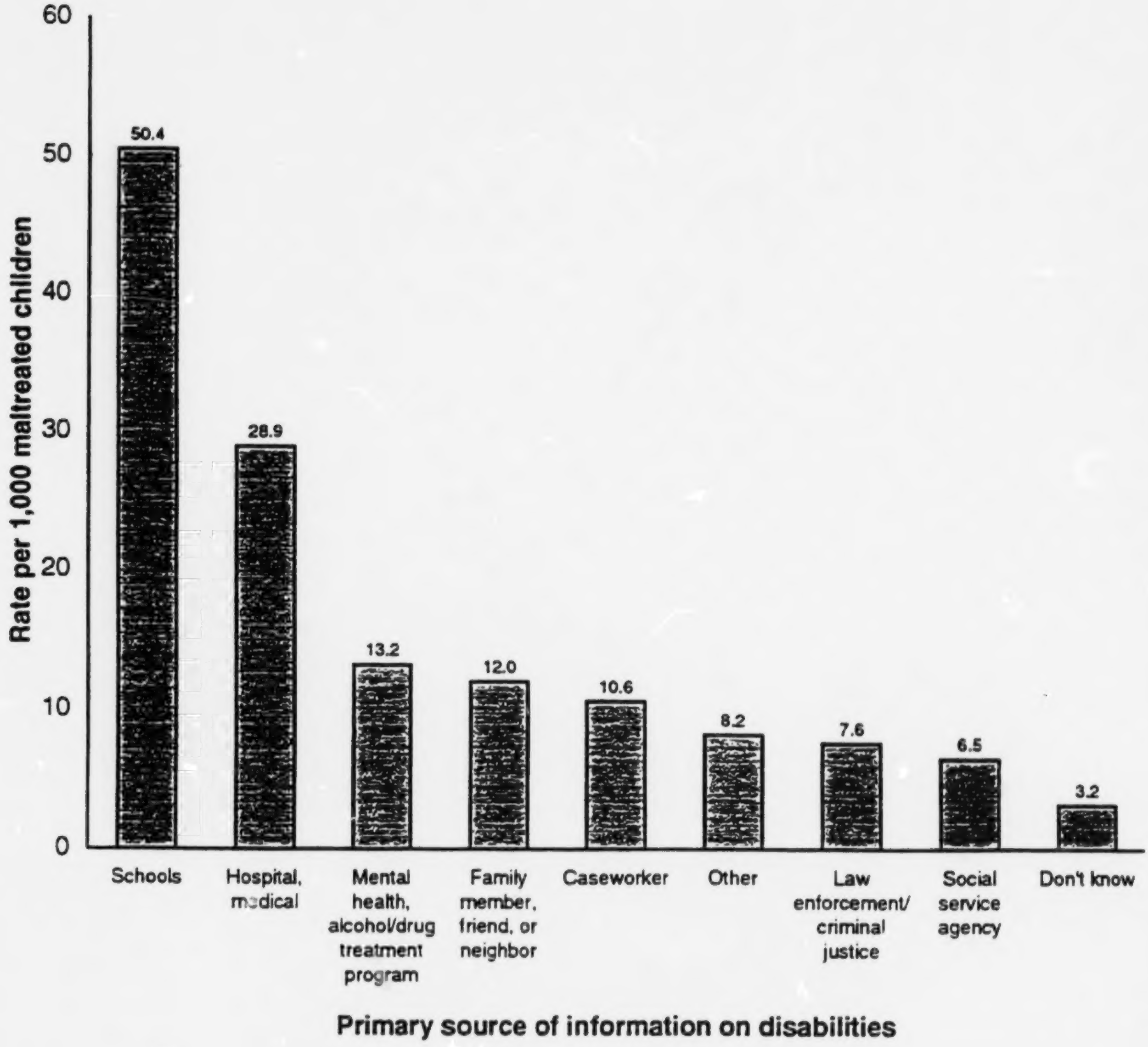
Additional information was obtained regarding the source of information for the disability. (See Figure 3-6.) Schools and medical sources were the most frequently used sources. The primary source of information that the caseworkers had about the disability was a professional source (i.e., social service agency, schools, medical, or mental health/drug or alcohol treatment program source) for almost 80 percent of the children with disabilities.

3.3.2 Case Processing at Substantiation

Initial case disposition was examined to determine if children with disabilities in the study had different case dispositions than children without disabilities. CPS caseworkers were asked to select the one case action taken (i.e., the case actions were mutually exclusive), at the time the case was substantiated, from the following choices: (a) case closed, no other action taken; (b) case open for ongoing protective services only; (c) case open for protective and preventive services; (d) case open for preventive services only; (e) child placed in foster care; (f) other; and (g) action pending. Since agencies vary on how they define and organize protective and preventive services, these categories were combined in the analysis. Note that the actual provision of services may differ from the services intended at the time of substantiation.

As shown in Table 3-10, 29.2 percent of all children without disabilities in the study had their cases closed after substantiation compared to only 15.2 percent for the children with disabilities in the study. Both for children with disabilities and children without disabilities, the most frequent case action was provision of protective and/or preventive services (53.7 percent and 47.9 percent, respectively). Surprisingly, placement rates for families with children with disabilities and for families without children with disabilities in the study were very similar (6.9 percent vs. 8.8

Figure 3-6. Estimated rate of maltreated children with disabilities (per 1,000 maltreated children) by primary source of information on disabilities



Note: The number of children in the study sample of maltreated children was 1,834.

Table 3-10. Percent of maltreated children with and without disabilities by initial case action

	Disabilities			
	Yes		No	
Initial case action	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample
Closed: No further action	15.2	36	29.2	416
Open: Protective and/or preventive services	53.7	133	47.9	825
Open: Foster care	6.9	29	8.8	159
Other	24.0	34	13.8	190
Don't know	-	1	-	9
Total	100	233	100	1,599

[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. A dash indicates that the estimated national number is less than 500.

percent, respectively). (Although an association between a child's disabilities and initial case action appears to exist, analyses revealed that this association is not statistically significant.)

The percentage of children in families with one or more children placed in foster care reflected only those children in foster care at substantiation. Hence, children who were placed during the investigation and returned home prior to substantiation would be excluded from the foster care placements. Information from Data Collection #2 indicated that about 14 percent of the maltreated children with disabilities were in families for which a foster care placement was made as a result of the maltreatment during the 3 to 4 months after substantiation. This is lower than the rate for maltreated subject children without disabilities (21.2 percent).

Additional analyses of case actions examined the distribution of child's age for each case action. Case actions for children with disabilities and children without disabilities differed dramatically by age. For children with disabilities in the study, case closings were least frequent for children under the age of 5 and then increased for children through age 9. (See Table 3-11.) They remained at that same level for children over the age of 9. Case closing rates for children without disabilities followed a similar pattern.

About a quarter of children with disabilities in each of the 4 and under, 5-9, 10-13, and 14-17 age categories received protective and/or preventive services. (See Table 3-12.) Only 10.6 percent of children without disabilities age 14-17 received services compared to 25.8 percent of the children with disabilities in the same age range.

Foster care placements were lower for children with disabilities than for children without disabilities at all ages except for those who were older.

As shown in Table 3-13, children whose disabilities led to maltreatment were about as likely to have their cases closed as other children with disabilities, but somewhat more likely to receive protective and/or preventive services. Analyses also revealed several relationships between initial case action and the extent to which caseworkers believed that maltreatment caused disabilities for children with maltreatment-related injuries. (See Table 3-14.) The percentage of children with maltreatment-related injuries whose cases were closed at substantiation decreased with the likelihood that the maltreatment was suspected to have caused disabilities. Children with

Table 3-11. Estimated rate of maltreated children whose cases were closed at substantiation with and without disabilities (per 1,000 maltreated children) by age of child

Age of child	Estimated rate of maltreated children whose cases were closed	
	Children with disabilities (per 1,000 maltreated children) (column %)	Children without disabilities (per 1,000 maltreated children) (column %)
Under 1 year - 4	5.2 (27.2)	59.4 (23.6)
5-9	7.1 (37.1)	94.9 (37.8)
10-17	6.8 (35.7)	97.0 (38.6)
Total	19.1 (100)	251.3 (100)

Note: The number of children in the study sample of maltreated children whose cases were closed, with disabilities, was 36; the number of children in the study sample of maltreated children whose cases were closed, without disabilities, was 416.

Table 3-12. Estimated rate of maltreated children whose families received protective and/or preventive services with and without disabilities (per 1,000 maltreated children) by age of child

Age of child	Estimated rate of maltreated children whose families received protective and/or preventive services	
	Children with disabilities (per 1,000 maltreated children) (column %)	Children without disabilities (per 1,000 maltreated children) (column %)
Under 1 year - 4	18.1 (22.3)	155.8 (38.1)
5-9	20.6 (25.4)	140.5 (34.3)
10-13	21.5 (26.5)	69.7 (17.0)
14-17	20.9 (25.8)	43.2 (10.6)
Total	81.1 (100)	409.2 (100)

Note: The number of children in the study sample of maltreated children whose families received protective and/or preventive services, with disabilities, was 133; the number of children in the study sample of maltreated children whose families received protective and/or preventive services, without disabilities, was 825.

Table 3-13. Percent of maltreated children with disabilities by whether or not disabilities were suspected by caseworker to have led to maltreatment and by initial case action

Initial case action	Disability led to maltreatment?			
	Yes		No	
	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample
Closed: No further action	10.1	9	13.7	22
Open: Protective and/or preventive service	61.9	34	53.6	71
Open: Foster care	–	7	11.5	19

[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used.

Table 3-14. Percent of maltreated children with maltreatment-related injuries by extent to which maltreatment was suspected by caseworker to have caused disabilities and by initial case action

Initial case action	Extent to which maltreatment caused disability: Definitely yes or likely (column %)	Extent to which maltreatment caused disability: Unlikely or definitely no (column %)
Closed: No further action	10.7	26.9
Open: Protective and/or preventive services	63.6	44.5
Open: Foster care	16.7	6.6

Note: The number of children in the study sample of maltreated children with maltreatment-related injuries was 452. Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. Information on the extent to which maltreatment caused a disability is from caseworker records and inferences.

maltreatment-related injuries were more likely to receive services or be placed in foster care as the likelihood that maltreatment-caused disabilities increased. These relationships may not be surprising given that the extent to which maltreatment caused disabilities is probably an indicator of the severity of the maltreatment.

These findings indicate that the presence of a disability affected the type of action taken by the child welfare agency. The actions taken varied considerably by child's age.

3.3.3 Case Processing After Substantiation

Study results on case processing after the substantiation of maltreatment indicate the amount and type of services provided to cases that remained open. Families with one or more maltreated children with disabilities received an average of 7.9 caseworker visits compared to an average of 5.1 family visits for families with maltreated children with no disabilities. Most of the family visits were focused on a relatively small number of families. Approximately 58 percent and 56 percent of the maltreated children with and without disabilities were in cases that received one or more services as a result of the maltreatment, respectively. As shown in Table 3-15, the percentage of families receiving any given service was fairly small for families with and without children with disabilities. Information on the duration and intensity of services was not collected.

When all case closings are considered, 75.6 percent of the cases closed for children with disabilities more than 90 days after substantiation, compared with 52.0 percent for children without disabilities. (See Table 3-16.) Of the cases that were opened after substantiation of maltreatment, maltreated children with disabilities and those without disabilities differed very little on the mean length of time that cases remained open before closing during the first 90 days after substantiation. The mean number of days that cases remained open before closing during this period was 46.1 days for children with disabilities and 48.9 days for children without disabilities.

Table 3-15. Percent of maltreated children with and without disabilities by services provided to families after substantiation of maltreatment

Service provided	Maltreated children with disabilities (weighted percent)	Maltreated children without disabilities (weighted percent)
Behavior management	10.5	7.1
Day care	-	6.2
Educational services	9.2	5.7
Employment/training	-	2.3
Habilitation/rehabilitation	4.6	6.2
Homemaker service	6.9	8.4
Household management	3.3	5.4
Housing assistance	6.7	6.1
Individual counseling	27.1	26.7
Family counseling	27.0	18.3
Other mental health services	12.6	10.2
Legal services	14.3	9.9
Medical services	23.2	14.7
Parent training	9.2	12.4
Peer support group	10.7	4.4
Respite care	-	1.6
Transportation	17.5	14.2
Other	10.1	7.6

Note: The number of children in the study sample of maltreated children was 803. Column totals exceed 100 percent because families may have received more than one service. Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used. A dash indicates that the estimated national number is less than 500. Information on the duration and intensity of services was not collected.

Table 3-16. Percent of maltreated children with and without disabilities by length of time cases remained open before closing

Length of time case remained open before closing	Disabilities			
	Yes		No	
	Weighted percent[a]	Number in sample	Weighted percent[a]	Number in sample
1 - 30 days	6.7	7	13.3	74
31 - 60 days	13.0	8	19.1	68
61 - 90 days	4.8	7	15.6	41
91 - 120 days	51.9	17	30.1	63
120 + days	23.7	12	21.9	60
Total	100	51	100	306

Note: This table is on maltreated children whose cases were open at substantiation. The percents of all maltreated children with disabilities whose cases were closed and open at substantiation were 15.2 percent and 60.6 percent, respectively; the percents of all maltreated children without disabilities whose cases were closed and open at substantiation were 29.2 percent and 56.7 percent, respectively.

[a] Percents are based on the estimated national numbers, which were weighted according to the stratified sampling design used.

4. RECOMMENDATIONS

Based on the results of this study, six recommendations are in order: (a) risk assessment approaches used in CPS agencies should include the child's specific disabilities as a risk factor; (b) CPS caseworkers should be educated on the relationship between maltreatment and disabilities, on identifying disabilities, and on making appropriate referrals for children with disabilities; (c) professionals who come into contact with children with disabilities should be educated on the relationship between maltreatment and disabilities, on identifying possible child maltreatment, and on making appropriate referrals for these children; (d) State and Federal systems for reporting information on cases of child maltreatment should include uniform information on whether or not children have disabilities; (e) caseworkers in CPS agencies and professionals in other settings should provide specialized services to prevent maltreatment in families with children with disabilities; and (f) future research should continue to study the relationship among child maltreatment, race/ethnicity, and disabilities, and on the causal relationship between disabilities and maltreatment. Each recommendation is briefly discussed in this chapter.

Risk Assessment Approaches Used in CPS Agencies Should Include the Child's Specific Disabilities as a Risk Factor

The study findings indicate that children with disabilities are over-represented among maltreated children. They also suggest that disabilities can lead or contribute to some types of maltreatment. CPS agencies that use risk assessment to investigate allegations of maltreatment and to plan services for substantiated cases of maltreatment should include each disability as a risk factor.

CPS Caseworkers Should Be Educated on the Relationship Between Maltreatment and Disabilities, on Identifying Disabilities, and on Making Appropriate Referrals for Children With Disabilities

CPS caseworkers are often the gatekeepers for a variety of services for children and families. In this role, caseworkers must be prepared to identify possible problems and respond appropriately to them. The study findings on the over-representation of children with disabilities among maltreated children indicate that disabilities are one such set of issues for which caseworkers should be well-prepared. Caseworkers need to be especially alert to the possibility of disabilities among children who experienced physical abuse, sexual abuse, or physical neglect and among pre-school children because these children are less likely to have disabilities identified by sources other than the CPS agency, such as schools. By providing training on the relationship between child maltreatment and disabilities and on how to identify these conditions, CPS agencies can better prepare caseworkers to meet children's needs. State developmental disabilities protection and advocacy agencies should be encouraged to participate in the education and training of CPS workers regarding appropriate referrals for children with disabilities.

Professionals Who Come into Contact With Children With Disabilities Should Be Educated on the Relationship Between Maltreatment and Disabilities, on Identifying Possible Child Maltreatment, and on Making Appropriate Referrals for These Children

This recommendation is the corollary of the previously listed one. Because children with disabilities appear to be at higher risk of being maltreated, service providers who have contact with children with disabilities should be especially alert to symptoms of maltreatment. These professionals should know what these symptoms are and how to ensure that they are properly investigated. They should also be aware of factors, in addition to having children with disabilities, that may increase the risk of maltreatment; when appropriate, these professionals should intervene to prevent maltreatment. The training of school and preschool personnel is especially important. While non-CPS agencies can provide training opportunities for their staff on the relationship between child maltreatment and disabilities and on how to identify child maltreatment, the impetus for such training may have to come from the CPS agencies. CPS agencies should be encouraged to offer training on these issues to agencies in their communities that have contact with children with disabilities. Federal and State assistance for developing and disseminating a curriculum for such training would facilitate the process.

State and Federal Systems for Reporting Information on Cases of Child Maltreatment Should Include Uniform Information on Whether or Not Children Have Disabilities

A recently completed survey of State CPS agencies on maltreated children (Westat, Inc., 1991) indicated that only a few States systematically differentiated cases involving children with disabilities from other cases. This survey also found that the definitions of disabilities that States used varied widely. Yet systems that regularly provide uniform information on the prevalence of disabilities among maltreated children could serve an important need assessment function. For example, these systems could inform social service planners at the State and national levels on the need for specialized services for these children. Such systems could also provide an early warning of trends in the maltreatment of children with disabilities.

Caseworkers in CPS Agencies and Professionals in Other Settings Should Provide Specialized Services to Prevent Maltreatment in Families With Children With Disabilities

Study findings on the extent to which disabilities led or contributed to maltreatment underline how caring for a child with disabilities can stress the emotional and financial resources of a family. Families of children with disabilities may require specialized services (e.g., parenting training and respite care) to help them to manage these strains if reoccurrences of maltreatment are to be prevented. While CPS agencies provide different services under the same label, the study findings suggest that families with maltreated children with disabilities are no more likely to receive these services than families with maltreated children without disabilities. Providing new specialized services may not be feasible for rural agencies and other agencies with stretched budgets. Short of providing new services, these agencies should consider how to access alternative services or to adapt existing services to meet the special needs of families with children with disabilities.

Future Research Should Continue to Study the Relationship Among Child Maltreatment, Race/Ethnicity, and Disabilities, and on the Causal Relationship Between Disabilities and Maltreatment

The study identified possible relationships among children's disabilities, maltreatment, and several other characteristics of cases. Of special interest are findings on maltreatment, race/ethnicity, and disabilities; on disabilities and initial case status; and on the causal relationship between maltreatment and disabilities. Future research should seek to replicate these findings. It should also seek to increase understanding of the causal relationships underlying these findings.

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APPENDIX A

Methodology

APPENDIX A

METHODOLOGY

In this appendix, additional information on the methods used for Data Collection #1 and Data Collection #2 is presented. These methods and the instruments for the data collections (presented in Appendices B and D) were used to collect information on child maltreatment, children's disabilities, and familial substance abuse. (To meet another requirement of P.L. 100-294, this study also collected information on child maltreatment and familial substance abuse.) The report provides results only on child maltreatment and disabilities. Sampling, recruitment of agencies, data collection, data processing, and weighting for Data Collection #1 and Data Collection #2 are discussed in separate sections.

A.1 Data Collection #1

In Data Collection #1, data were collected from Child Protective Services (CPS) workers on recently substantiated cases of maltreatment.

A.1.1 Sampling

The substantiated cases in this study are a nationally representative sample of cases of child maltreatment that were substantiated by CPS agencies. The samples of cases were drawn from 36 nationally representative CPS agencies during a 4- or 6-week period.

A.1.1.1 Sample Size and Precision

In considering sample design options for the study, one must keep in mind the ultimate use for the study estimates and the context in which they will be considered. The study data give direct estimates of the proportion of substantiated cases of maltreatment to children with disabilities and those in alcohol or drug abusing families. Such estimates relate to a data collection period of 4 or 6 weeks. The major focus of interest, however, is the numbers of children with disabilities maltreated within a year, rather than just the proportion of the population with disabilities.

In many cases, the results of the present study were analyzed in conjunction with estimates from the Study of the National Incidence and Prevalence of Child Abuse and Neglect (NIS-2) and other previously conducted studies. In judging the reliability needed for estimates from the present study, one must consider the reliability of these other sources of estimates. For example, consider an estimate of y of Y, the total number of maltreated children with disabilities in the U.S. in a one-year period. This estimate may be obtained as:

$$\hat{y} = \hat{p}\hat{x}$$

where $\hat{p}$ is the estimated proportion of maltreated children who have disabilities, derived from data obtained in the study, and x denotes the annual estimated incidence of the number of children maltreated, obtained from NIS-2. The relative reliability of this estimate, expressed as the coefficient of variation, is given approximately as:

$$CV(\hat{y}) = \sqrt{(CV(\hat{p}))^2 + (CV(\hat{x}))^2}$$

where CV denotes the coefficient of variation. Hence, the precision depends upon the relative precisions of both the NIS-2 estimate of total incidence and the proposed study estimate of the proportion of those maltreated who have disabilities.

The study plan called for a sample of 2,000 substantiated cases to be drawn. The NIS-2 estimate of substantiated CPS cases nationally is 871,000 for a one-year period. This corresponds to an average of about 30 substantiated cases per agency per month, as there are about 2,500 agencies nationally. In order to obtain a sample of about 2,000 cases, a probability sample of 36 agencies was drawn. The coefficient of variation of the NIS-2 estimate of 871,000 is 0.136. Based on an expected proportion of maltreated children with disabilities of 0.25, the coefficient of variation of the estimate p for a sample of 2,000 is:

$$CV(\hat{p}) = .039 \sqrt{Deff}$$

where Deff denotes the design effect. The design effect in this case reflects the increase in sampling error that will result from sampling cases clustered within selected agencies, rather than throughout the population. The design effect can be expressed approximately as:

$$\text{Deff} = 1 + (\bar{n} - 1)\, q,$$

where $\bar{n}$ is the average number of cases selected per selected agency, and q denotes the interclass correlation. The interclass correlation measures the extent to which the proportion of maltreated children who have disabilities varies from agency to agency. In surveys of human populations in natural clusters (e.g., counties), the value of q can vary from close to zero for characteristics that vary little from cluster to cluster, to as high as 0.25 for highly clustered characteristics. The proportion of maltreated children who have disabilities is likely to be only moderately variable across counties or agencies; the proportion who are from alcohol or drug abusing families may vary somewhat more. Based on experience from a variety of surveys of human populations, a value for q of 0.05 is likely to be a suitable approximation.

For a design with 2,000 cases drawn from 36 agencies, with an average of 57 cases per agency (so that large agencies will be sampled with greater probability than small agencies, as the national average is approximately 30 cases per agency), the design effect will be:

$$\text{Deff} = 1 + 56 \times .05 \approx 3.8$$

The level of sampling error for the estimate of the proportion of substantiated maltreatment cases who have disabilities (and similarly for the proportion in alcohol or drug abusing families) is about 3.8 times as great as would be the case if a simple random sample of 2,000 substantiated cases were drawn from among all such cases in the U.S. during a 4-week period. (Such a simple random sample would result in selecting typically one or no cases from a very large proportion of the approximately 2,500 agencies nationwide.)

Based on these various assumptions, the design resulted in a coefficient of variation for the estimated total number of children with disabilities who are maltreated in a year, $\hat{y}$, as:

$$CV(\hat{y}) = \sqrt{(CV(\hat{p}))^2 + (CV(\hat{x}))^2}$$

$$= \sqrt{(.039)^2 \times \text{Deff} + (.136)^2}$$

$$= \sqrt{(.039)^2 \times 3.8 + (.136)^2}$$

$$= \quad 0.156$$

Hence, the coefficient of variation for this estimated total is about 16 percent using this design. The information is adequate to provide reliable estimates from the study.

A.1.1.2 Selecting the Agency Sample

The basic approach that was implemented involved drawing a stratified probability sample of 36 counties from throughout the U.S. The use of county sampling as a means of obtaining agencies was effective because, for the most part, agencies operate along county lines; and useful information is available for counties for use in stratification and deriving measures of size. In this section, the sampling frame used and how the agency sample was selected are discussed.

Sampling Frame

The sampling frame consists of 3,185 counties (or pseudocounties in some cases) from throughout the U.S. The data were obtained from "County and City Data Book, 1988, Files on Tape," prepared by the U.S. Bureau of Census. The information included school enrollment, county metropolitan status, and county median household income in 1979.

In those cases where agencies are not organized along county lines, such as in the States of Massachusetts, Connecticut and Alaska, "pseudocounties" were created corresponding to the area served by each agency.

- For Massachusetts, a list of the communities served by the area offices was obtained from "Public Welfare Directory, 1989-90," prepared by the American Public Welfare Association. The total population for these communities were obtained from the County and City Data Book. The community level data were aggregated to obtain the total population for area offices. The State level proportion of school enrollment to total population was applied to the agency total population to estimate the agency school enrollment.

- For Connecticut agencies, a list of the communities served and their total population was available from "The National Directory of Children and Youth Services, 1990-91." The school enrollments for agency areas were estimated by using the State proportion of school enrollment in total population.
- The county equivalents for Alaska were the organized boroughs/census areas. The information on the agencies (field offices) was obtained from "Public Welfare Directory, 1989-90," prepared by the American Public Welfare Association. Correspondence between the boroughs/census areas and the field offices was established.

Efforts were made to divide the large agencies (counties) in the sampling frame into their subagencies, and to obtain information on the relative size of their caseload. If such large agencies were included on the sampling frame as a single unit, and one was selected, two possibilities would be faced. The first would be to collect data from all its subagencies, thus substantially increasing the level of effort required in data collection. The alternative would be to sample subagencies, which might have led to a significant shortfall in the overall number of cases obtained. Sampling subagencies could also produce loss of efficiency in the sample design, as the cases from subsampled agencies would require substantially greater weights than the rest of the units. Several large agencies were contacted. If their subagencies existed and data were available at the subagency level, these agencies were replaced by their subagencies in the frame. These agencies are as follows:

- Maricopa County, AZ - The caseload data were obtained for its one central and seven field offices. Thus, it was divided into eight subagencies.
- Dade County, FL - The caseload data for the month of September 1989 were obtained for its one main and four field offices. Thus, it was divided into five subagencies.
- Los Angeles County, CA - The data for the month of September 1989 were obtained for its six regions. It was divided into six regional offices.
- San Diego County, CA - Estimated average monthly caseload data were obtained for Metro (downtown) office, and two offices (combined) in the North County. It was divided into two subagencies.
- New York City, NY - The caseload data were obtained for five boroughs.
- Orange County, CA - Did not have subsidiary offices.

- Cook County, IL - Composed of a main office and an outpost, but the data were not available separately for these offices.
- Dallas County, TX - Composed of one central office and no field offices.
- Wayne County, MI - Composed of a main office and an outpost, but the data were not available separately for these offices.

Sample

The sample was to consist of 36 agencies (PSUs). To this end, the PSUs were stratified into two size classes. School enrollment was used as a size measure. A cut-off point was delineated at 53,122 students. The sample was allocated to small and large strata as 28 and 8 units, respectively. This design was expected to yield 2,000 substantiated cases in a one-month period while the sampling rates differed as little as possible between the two strata. The PSUs were further stratified by the level of urbanicity (MSA, non-MSA), and by the county median household income. The resulting six sampling strata and the number of PSUs in the sampling frame are shown in Table A-1. Initially, the sample was allocated to strata 1 to 6, in the stratum numbering order as 11, 11, 3, 3, 4, 4. However, later the decision was made to increase the number of cases while keeping the number of agencies constant. Thus, the sample sizes in the large PSU strata were increased, and the sample sizes in the small PSU strata were decreased (see Table A-1).

Table A-1. Population and sample sizes by sampling stratum

Sampling stratum	School enrollment size classes	Metro status	Household income size classes	Population size	Sample size
1	53,212	Non-MSA	13,056	1,194	7
2	53,212	Non-MSA	13,057	1,194	7
3	53,212	MSA	17,140	307	3
4	53,212	MSA	17,141	307	3
5	53,213	All	17,795	92	8
6	53,213	All	17,796	91	8

An equal probability systematic sample was selected from each stratum independently. Before the sample selection, the PSUs in each stratum in the frame were ordered by census region and by FIPS State code within region in strata 1 and 2. They were also ordered by county school enrollment in strata 3 to 6.

A.1.1.3 Selecting Cases Within Agencies

As indicated in the above discussion, all substantiated cases from a participating agency for a 4- or 6-week period were selected. This approach had two main advantages. First, it was simple for the participating agency to administer, as it was unnecessary to maintain and adhere to a within-agency sampling procedure. Also, the potential for errors in the sampling procedure was reduced. The second advantage was the possibility of obtaining the 2,000 cases within a 4- or 6-week period from 36 agencies, with minimal variation across the full sample in the probability of selection of individual cases. Use of within-agency sampling would require either a longer data collection period, a larger sample of agencies, or a greater variation in sampling weights. This would lead to a somewhat decreased precision.

The proposed procedure has one potential disadvantage. The 4- or 6-week data collection period could result in sampling biases associated with seasonal variation in the reporting of maltreatment to CPS agencies. The most serious biases were likely to occur if data were collected on cases reported during the summer months, when school was in recess. For example, selecting such a month could lead to underreporting of maltreatment because school personnel would be eliminated as a source of reports. It could also skew survey results on the types of maltreatment reported (e.g., educational neglect is likely to be underreported). To counter this potential problem, the study collected data on cases that were reported during months in which school was in session. To detect other potential biases associated with seasonal variation in the reporting of cases, information was also collected from agency personnel on the numbers of cases reported each month over a year and on reasons for any variation in these numbers.

A.1.2 Recruitment of Agencies

Once the sample of CPS agencies was drawn, recruitment of these agencies to participate in the study began. Initial reluctance on the part of agency directors and CPS staff to participate in the study was anticipated, since they may already be overburdened with paperwork. However, the necessary cooperation of nearly all the CPS agencies was obtained prior to the clearance of data collection instruments.

Initial contacts were made by the use of advance mailings to State level officials who have oversight for the sampled agencies. These mailings explained the purpose of the study and asked their permission to recruit the selected CPS agencies. CPS agencies can be classified into two types: county-administered and State-administered organizational structure. In State-administered CPS agencies, all necessary approvals came from the cognizant State agency. Decisions at the State level usually committed the CPS agency to participation. In county-administered CPS agencies, the purpose of securing State approval was to obtain permission to recruit the local agencies, rather than to commit these agencies.

The initial State-level mailing was followed by a phone call from Westat senior project staff to obtain the appropriate procedures for obtaining approval in that State for local agency participation in the study. These procedures were followed and, at the appropriate point, the name of the sampled CPS agency authority who could negotiate detailed data collection arrangements was obtained.

After obtaining State-level approval to contact this local authority, recruitment discussions with the individual sampled CPS agencies began. At the local level, an introductory recruitment letter to each agency was sent, and senior staff made telephone followup contacts. This contact and subsequent conversations focused on gaining a thorough understanding of that CPS agency's procedures. Thus, it allowed tailoring the data collection approach to the specific needs and constraints of that agency.

Information from the agency was obtained on procedures they use to assign cases to individual caseworkers (especially if there are indications of the child having disabilities, or coming from a family with an alcohol or drug abuse problem), training programs they may offer to workers to serve cases with children who have disabilities or are from alcohol or drug abusing families, and other readily available information that enabled the efficient collection of data. A letter confirming the specific data collection arrangements was sent to each participating CPS agency.

A.1.3 Data Collection

Data Collection #1 can be divided into activities that occurred prior to and during the actual receipt of information from the CPS agencies in our sample. Once clearance from the Office of Management and Budget (OMB) was received, communication with the agencies to schedule the data collection period began. Materials were mailed to contact persons at the agencies to assist them in preparing for data collection. These materials included sample instruments, instructions for the caseworkers on completing the instruments, and instructions for the contact persons. The instructions for the contacts guided them in training the caseworkers to identify appropriate cases for the study and how to complete study forms. Telephone contacts were made with the contacts to discuss the materials and answer questions.

Once the contacts were trained, supplies were mailed to them for the caseworkers to use. These supplies included copies of forms, instructions, glossary of terms, and self-addressed business reply envelopes. They also included prepaid self-addressed overnight mail envelopes. The agency contacts were asked to use these envelopes to transmit forms that were completed after the first few days of data collection. By reviewing these forms, problems could be identified and corrected early in the data collection period.

The agencies began data collection between February 4, 1991 and March 11, 1991. Once data collection began for an agency, regular telephone calls were made to the contacts, usually about once every one to two weeks. In these calls, questions were answered, and attempts were made to identify and correct problems.

During the data collection, an automated receipt control system was used to monitor the receipt of forms. As forms were received, information on each one was entered into this system. Weekly reports were prepared on the number of cases that were received from each agency. This information helped to identify potential problems at some agencies. When problems were suspected at an agency, the contact at that agency was telephoned.

After the data collection began, reports from the receipt control system indicated that an insufficient number of cases would be collected at the rate they were arriving. The agencies were asked to extend the data collection period from 4 to 6 weeks. All but seven of the agencies agreed to the extension.

A.1.4 Data Processing

After a sufficient number of forms were received, coding of the forms began as preparation for data entry. Coding manuals were developed for the instrument. This codebook contains information on the following:

- Question number and item descriptions for each codable item;
- Field column locations for all codable items;
- Codes for all possible responses;
- Coding of nonresponse categories is consistent for all data items;
- Special editing instructions in the form of "editing checklists" and "edit boxes"; and
- Procedures for assuring that each record is uniquely identified.

The codebook specifications helped to minimize the possibility of entry error.

Data preparation operators (coders) were trained shortly after OMB clearance. After training, coding began with each coder's work 100 percent verified by the supervisor until the operator demonstrated acceptable proficiency. Following this introductory period, a random sample of each coder's work was verified at regular intervals. While the data collection instrument is composed of closed-ended questions, some of these questions also permitted open-ended responses (e.g., "other, specify"). These responses were coded by trained and experienced staff.

All data entry was 100 percent key verified for accuracy. Resultant data files were cleaned using machine edits. When these edits produced exceptions, the exceptions were examined and rectified by the data preparation supervisor or, if necessary, the project director. Rectifying exceptions and collecting previously missing data frequently required the data collection supervisor to telephone individual caseworkers. Clean files were created after all records passed the machine edits.

A.15 Weighting and Variance Estimation

In this section, we briefly describe the weighting and variance estimation approaches that we used.

A.15.1 Weighting

The weights were constructed at the agency level. The first step in weighting was to compute the probability of selection for each agency in the sample. The probability of selection for the i-th agency in the h-th stratum $SELPROB_{hi}$ is:

$$SELPROB_{hi} = \frac{n_h}{N_h}$$

where n_h is the number of PSUs in the sample and N_h is the number of PSUs in the sampling frame in the h-th stratum.

For one agency, a special adjustment was necessary because two agency areas were included as separate PSUs in the sampling frame. However, the case data were unavailable separately from these agencies. The selection of either agency to the sample would have resulted in the inclusion of both into the survey. Let C_1 refer to the event that the agency was selected and C_2 refer to the event that one of the two areas was selected. Then:

$$P(C_1 \cup C_2) = P(C_1) + P(C_2) - P(C_1 \cap C_2)$$

Both agencies were in the same stratum; therefore their selection probabilities are not independent.

$$P(C_1 \cap C_2) = P(C_1 \mid C_2) \times P(C_2)$$

In Stratum 4 of the sampling frame, the agency areas were located in their selection order, as the 251st unit and 255th unit. Because the selection interval for this stratum is 102, $P(C_1 | C_2) = 0$. Thus,

$$\begin{aligned} P(C_1 \cup C_2) &= P(C_1) + P(C_2) \\ &= 2 \times P(C_1) \end{aligned}$$

The probability of selection of this PSU is:

$$SELPROB = \frac{2 \times n_h}{N_h}$$

The next step was to construct the baseweight for each agency as a reciprocal of their probability of selection:

$$BASEWT_{hi} = \frac{1}{SELPROB_{hi}}$$

For various reasons, adjustments to the baseweights were required for several agencies:

- Agency A, originally selected, refused to participate. The agency serving County B was used as a substitute. B County is similar in some characteristics to County A but smaller in size. The school enrollment is 296,512 for A County and 119,811 for County B. Therefore, a substitution adjustment factor was computed (to be multiplied by its baseweight) as:

  $$SUBSAF = \frac{296{,}512}{119{,}811}$$

  It was set equal to 1 for all other agencies.

- Site C area office refused to participate in the survey. Site D office was used as a substitute. The estimated school enrollments for these areas were quite similar (86,099 for C and 92,826 for D) so that no adjustment for the weight was required. Thus, a weight adjusted for substitution SADWT was computed as:

  $$SADWT_{hi} = BASEWT_{hi} \times SUBSAF_{hi}$$

- Agency E did not provide information for the survey. The weights were adjusted for this nonresponse. Agency E was in sampling stratum 2. A nonresponse adjustment factor was computed in stratum 2 (e.g., for h=2) as:

$$NRAF_h = \frac{\sum_i SADWT_{hi} \times ENROL_{hi} \times I_{hi}}{\sum_i SADWT_{hi} \times ENROL_{hi}}$$

where I_{hi} is 0 for Agency E and 1 for all other PSUs in the stratum 2; and $ENROL_{hi}$ is the school enrollment for the i-th PSU in the stratum 2. $NRAF_h$ was set equal to 1 for PSUs in all other strata. Then, the nonresponse adjusted weight NRADWT is:

$$NRADWT_{hi} = NRAF_h \times SADWT_{hi}$$

- The agency serving County F did not provide data for the neglect cases. Therefore, it was necessary to construct a weight adjusted for this nonresponse for the estimation of neglect cases. This agency was in sampling stratum 6. First, a nonresponse adjustment factor for neglect cases N_NRAF_h in stratum 6 (e.g., for h=6) was computed as:

$$N\_NRAF_h = \frac{\sum_i NRADWT_{hi} \times ENROL_{hi}}{\sum_i NRADWT_{hi} \times ENROL_{hi} \times \delta_{hi}}$$

where δ_{hi} is 0 for County F and 1 for all other PSUs in the stratum 6; and $ENROL_{hi}$ is the school enrollment in the i-th PSU in the stratum 6. N_NRAF_h is set equal to 1 for PSUs in all other strata. Then, a nonresponse adjusted weight for neglect cases N_NRADWT was computed as:

$$N\_NRADWT_{hi} = N\_NRAF_h \times NRADWT_{hi}$$

In general, within a participating agency all newly substantiated cases for a 6-week period were included in the sample. For a few agencies the data were collected only for a 4-week period. A data collection time period differential adjustment factor DCTDAF was constructed by setting it equal to 1.5 for the agencies with 4-week data collection, and to 1 for the agencies with 6-week data collection.

Each agency was asked to provide information on its average monthly substantiated caseload. For each sampling stratum, an adjustment factor was computed as a ratio of the weighted sum of the agency average monthly caseload (inflated to a 6-week period) to the weighted sum of the agency caseload reported during the 6-week data collection period. Then, the weights in each stratum were multiplied by its adjustment factor. The adjustment factors, from strata 1 to 6, were: 2.1, 1.8, 3.8, 1.3, 2.3, 2.1.

The agencies in the sample, their weights, and weight adjustment factors are shown in Table A-2.

After two weights, A_WT and N_WT, were computed at the agency level, they were assigned to the substantiated cases by the following procedure:

- A variable called MTYPE was constructed for each substantiated case by setting it equal to 1 if any child belonging to that case is abused, and equal to 2 otherwise. Then the final weight for the j-th substantiated case in the i-th agency and h-th stratum is:

$$\mathrm{FINWT}_{hij} = \begin{matrix} \mathrm{A\_WT}_{hi} & \text{if } \mathrm{MTYPE}_{hij} = 1 \\ \mathrm{N\_WT}_{hi} & \text{if } \mathrm{MTYPE}_{hij} = 2 \end{matrix}$$

- All children belonging to the same case were assigned the same weight as the case (e.g., $\mathrm{FINWT}_{hijk} = \mathrm{FINWT}_{hij}$ for all kj where k refers to the child).

A.1.5.2 Variance Estimation

The survey errors were estimated by the jackknife method. The estimation of survey errors has two major steps: (a) construction of replicate weights for each case, (b) the computation of the estimates of survey errors by using these replicate weights.

The replicates were obtained by dropping a PSU from the sample for each replicate. For each PSU a replicate weight was constructed by multiplying the full sample weight WT by 0 in that PSU, by n_h/n_h-1 for all other PSUs in the stratum the PSU belongs, and by 1 for PSUs in other strata. Thus, 36 replicate weights WT1-WT36 were obtained. The full sample weighting steps starting with the nonresponse adjustment for one county were repeated for each replicate weight. This process resulted in 36 final replicate weights, FINWT1-FINWT36.

Table A-2. Agency sample selection probabilities, weight adjustment factors, and weights

Sampling stratum	Agency ID	School enroll-ment	Probability of selection	Base weight	Substi-tution factor	Non-response adjust-ment factor	Data collection time period differential adjustment factor	Non response adjustment factor for neglect cases	Adjust-ment factor	Weight for abuse cases	Weight for neglect cases
1	06	4,842	0.005863	170.571	1.00	1.000	1.0	1.000	2.1	358.200	358.200
1	03	1,922	0.005863	170.571	1.00	1.000	1.5	1.000	2.1	537.300	537.300
1	07	5,346	0.005863	170.571	1.00	1.000	1.0	1.000	2.1	358.200	358.200
1	04	2,939	0.005863	170.571	1.00	1.000	1.0	1.000	2.1	358.200	358.200
1	02	1,729	0.005863	170.571	1.00	1.000	1.0	1.000	2.1	358.200	358.200
1	01	1,715	0.005863	170.571	1.00	1.000	1.0	1.000	2.1	358.200	358.200
1	05	3,491	0.005863	170.571	1.00	1.000	1.0	1.000	2.1	358.200	358.200
2	08	2,512	0.005863	170.571	1.00	0.000	1.0	0.000	1.8	0.000	0.000
2	12	5,997	0.005863	170.571	1.00	1.066	1.0	1.000	1.8	319.514	319.514
2	10	4,905	0.005863	170.571	1.00	1.066	1.0	1.000	1.8	319.514	319.514
2	13	8,815	0.005863	170.571	1.00	1.066	1.0	1.000	1.8	319.514	319.514
2	11	5,090	0.005863	170.571	1.00	1.066	1.0	1.000	1.8	319.514	319.514
2	14	10,055	0.005863	170.571	1.00	1.066	1.0	1.000	1.8	319.514	319.514
2	09	3,277	0.005863	170.571	1.00	1.066	1.0	1.000	1.8	319.514	319.514
3	15	5,597	0.009772	102.333	1.00	1.000	1.0	1.000	3.8	391.876	391.876
3	16	14,163	0.009772	102.333	1.00	1.000	1.0	1.000	3.8	391.876	391.876
3	17	27,011	0.009772	102.333	1.00	1.000	1.0	1.000	3.8	391.876	391.876
4	18	8,388	0.009772	102.333	1.00	1.000	1.0	1.000	1.3	133.033	133.033
4	19	20,932	0.009772	102.333	1.00	1.000	1.0	1.000	1.3	133.033	133.033

Table A-2. Agency sample selection probabilities, weight adjustment factors, and weights (Cont.)

Sampling stratum	Agency ID	School enroll-ment	Probability of selection	Base weight	Substi-tution factor	Non-response adjust-ment factor	Data collection time period differential adjustment factor	Non response adjustment factor for neglect cases	Adjust-ment factor	Weight for abuse cases	Weight for neglect cases
4	20	72,235	0.019544	51.167	1.00	1.000	1.0	1.000	1.3	66.517	66.517
5	21	56,118	0.086957	11.500	1.00	1.000	1.0	1.000	2.3	26.967	26.967
5	22	60,849	0.086957	11.500	1.00	1.000	1.0	1.000	2.3	26.967	26.967
5	23	76,386	0.086957	11.500	1.00	1.000	1.0	1.000	2.3	26.967	26.967
5	24	92,113	0.086957	11.500	1.00	1.000	1.0	1.000	2.3	26.967	26.967
5	25	109,159	0.086957	11.500	1.00	1.000	1.5	1.000	2.3	40.451	40.451
5	26	133,144	0.086957	11.500	1.00	1.000	1.0	1.000	2.3	26.967	26.967
5	27	183,824	0.086957	11.500	1.00	1.000	1.5	1.000	2.3	40.451	40.451
5	28	266,425	0.086957	11.500	1.00	1.000	1.0	1.000	2.3	26.967	26.967
6	29	54,944	0.087912	11.375	1.00	1.000	1.0	1.079	2.1	23.895	25.785
6	30	61,334	0.087912	11.375	1.00	1.000	1.0	1.079	2.1	23.895	25.785
6	31	71,509	0.087912	11.375	1.00	1.000	1.5	0.000	2.1	35.843	0.000
6	32	92,826	0.087912	11.375	1.00	1.000	1.5	1.079	2.1	35.843	38.678
6	33	103,487	0.087912	11.375	1.00	1.000	1.5	1.079	2.1	35.843	38.678
6	34	123,005	0.087912	11.375	1.00	1.000	1.0	1.079	2.1	23.895	25.785
6	35	172,219	0.087912	11.375	1.00	1.000	1.0	1.079	2.1	23.895	25.785
6	36	119,811	0.087912	11.375	2.47	1.000	1.5	1.079	2.1	88.706	95.720

After the replicate weights were constructed, the estimates for variances were computed by using the WESVAR procedure in SAS software. In the WESVAR procedure the METHOD option was set to JK2, and the FACTOR statement included the following 36 numbers:

.857 .857 .857 .857 .857 .857 .857 .857 .857 .857 .857 .857 .857 .857 .667 .667 .667 .667 .667 .667 .875
.875 .875 .875 .875 .875 .875 .875 .875 .875 .875 .875 .875 .875 .875 .875.

The procedure used by WESVAR can be summarized as follows. Let X_j denote a characteristic defined for each substantiated case j. An estimate for the population total for this characteristic is computed as:

$$X_{.} = \sum_{j} FINWT_j \times X_j$$

where $FINWT_j$ is the full sample weight for the j-th case. Another 36 estimates are computed similarly by using the replicate weights:

$$X_r = \sum_{j} FINWT_{rj} \times X_j$$

where r refers to the replicates r= 1,....,36. Finally, an estimate for the variance for this estimate is computed by:

$$V = \sum_{r=1}^{36} z_r (X_r - X_{.})^2$$

where z_r are constants placed in the FACTOR statement of the WESVAR procedure.

A.1.6 Adjustments to the Rate of Disabilities Among Maltreated Children

The data collected from CPS agency workers were used to estimate the rate of disabilities among children whose maltreatment was substantiated. These data indicated that among children who have had CPS substantiated maltreatment, 14.1 percent have disabilities. The key qualifier in this estimate is "children who have had CPS substantiated maltreatment." The 14.1 percent rate should be statistically adjusted to an appropriate disability rate for all maltreated children.

A prior study, The National Incidence of Child Abuse and Neglect (NIS-2), indicated that children whose maltreatment is reported to, and substantiated by, CPS agencies have different demographic characteristics than those children whose maltreatments are not reported to CPS agencies. In order to adjust the current study's disability rate for this difference in characteristics, the 14.1 percent rate was disassociated into disability rates for various demographic classes of children for whom the frequencies of occurrence of these demographic classes are known for both the current study and for NIS-2. These disassociated disability rates can then be applied to the frequency rates of all maltreated children from NIS-2 to derive an estimate of the disability rate among all maltreated children.

Table A-3 displays the results of this kind of analysis. The demographic characteristics selected were age, race, and sex of the maltreated child. These three variables are available from both the current study and from NIS-2. Column D of this table provides the rate of disability among the CPS substantiated maltreated children from the current study (weighted). For example, line 7 indicates that 12.2 percent of White females, under the age of 2, whose maltreatment has been substantiated by CPS, are estimated to have disabilities. Column E lists the percentage of all substantiated maltreated children who fall into the respective demographic categories. This column sums to 100 percent. For example, line 7 indicates that an estimated 7.0 percent of substantiated maltreated children are White females under the age of 2.

Taking the cross products of columns D and E and summing them, yields the 14.1 percent disability rate (see bottom of column F) found in the current study. In column G, the distribution of demographic categories are presented for all maltreated children, as estimated from the NIS-2 data. Taking the cross products of these rates and the disassociated disability rates of column D and summing them, yields an estimated 18.4 percent disability rate (see bottom of column H) for all maltreated children. Thus, the 14.1 percent disability rate appears to be an underestimate of the degree to which maltreated children have disabilities.

This finding can be tempered by two factors. First, the NIS-2 data were collected in 1986, and the current study data are for 1991. A change in the demographic characteristics of

Table A-3. Rates of disabilities by distribution of demographic characteristics of maltreated children

A	B	C	D	E	F	G	H
Age	Race	Sex	Among CPS substantiated, percent having disabilities	Percent of CPS substantiated children	Product of columns D and E	Percent of all harm std. children	Product of columns D and G
Birth to 2	W	M	8	6.2	0.5	1.6	0.1
		F	12	7.0	0.9	1.7	0.2
	B	M	17	3.8	0.7	0.8	0.1
		F	4	4.7	0.2	0.5	0.0
	H	M	0	0.6	0.0	0.4	0.0
		F	8	1.0	0.1	0.3	0.0
	Other	M	23	0.2	0.0	0.3	0.1
		F	10	0.3	0.0	0.3	0.0
3 to 5	W	M	34	5.1	1.7	3.8	1.3
		F	7	2.7	0.2	3.0	0.2
	B	M	8	2.7	0.2	0.7	0.1
		F	6	2.4	0.1	0.4	0.0
	H	M	15	0.7	0.1	0.4	0.1
		F	4	1.1	0.0	1.0	0.0
	Other	M	20	0.1	0.0	0.6	0.1
		F	16	0.3	0.0	0.5	0.1
6 to 8	W	M	26	5.6	1.5	5.2	1.4
		F	4	5.6	0.2	3.3	0.1
	B	M	13	4.2	0.5	1.9	0.2
		F	5	2.2	0.1	1.9	0.1
	H	M	18	1.2	0.2	0.4	0.1
		F	3	0.7	0.0	0.6	0.0
	Other	M	3	0.7	0.0	0.4	0.0
		F	0	0.1	0.0	0.8	0.0
9 to 11	W	M	22	6.2	1.3	4.5	1.0
		F	3	5.3	0.2	4.6	0.2
	B	M	14	1.9	0.3	1.4	0.2
		F	1	2.6	0.0	1.1	0.0
	H	M	15	0.5	0.1	1.0	0.1
		F	4	0.6	0.0	0.8	0.0
	Other	M	34	0.2	0.1	0.6	0.2
		F	0	0.3	0.0	0.1	0.0

Table A-3. Rates of disabilities by distribution of demographic characteristics of maltreated children (cont.)

A Age	B Race	C Sex	D Among CPS substantianted, percent having disabilities	E Percent of CPS substantiated children	F Product of columns D and E	G Percent of all harm std. children	H Product of columns D and G
12 to 14	W	M	42	4.4	1.8	7.0	3.0
		F	10	5.9	0.6	7.9	0.8
	B	M	8	1.1	0.1	2.4	0.2
		F	10	1.7	0.2	3.2	0.3
	H	M	17	0.4	0.1	0.8	0.1
		F	9	1.0	0.1	1.8	0.2
	Other	M	17	0.2	0.0	0.3	0.1
		F	0	0.2	0.0	0.9	0.0
15 to 17	W	M	46	1.0	0.4	6.4	2.9
		F	13	5.0	0.6	10.7	1.4
	B	M	16	0.5	0.1	1.6	0.3
		F	35	1.5	0.5	6.8	2.4
	H	M	14	0.2	0.0	2.1	0.3
		F	0	0.4	0.0	1.0	0.0
	Other	M	0	0.1	0.0	0.8	0.0
		F	26	0.1	0.0	1.3	0.3
		Percent with disabilities			14.1		18.4

maltreated children (or substantiated maltreated children) may have occurred over that 5 year period. If so, the 18.4 percent figure may be suspect. Second, both the current study and the NIS-2 study relied on samples of maltreated children and, hence, estimated disability rates and demographic distributions are subject to a statistical variance that may exceed the difference between the 14.1 and 18.4 percent disability rates.

With regard to the first factor, an analysis was conducted on the demographic distribution of CPS substantiated cases from both the current and the NIS-2 studies. To see if the difference over time of these demographic distributions affected estimates of rates of disability, a table similar to Table A-3 was constructed. The difference was that the demographic distribution of substantiated maltreated children from NIS-2 was substituted for the demographic distribution of all maltreated children from NIS-2 in column G. The resulting estimate of disability rate for substantiated maltreated children from NIS-2 is slightly higher than the rate that was estimated from the current study. Thus, the difference between the 14.1 percent disability rate of the current study and the 18.4 percent rate estimated for all maltreated children is most likely due to both differences in the demographic characteristics of reported and non-reported children and to differences between 1986 and 1991 data.

Taking this finding in combination with the second factor, that the difference in estimated rates may be due to statistical variance, led to the decision not to adjust the 14.1 percent rate of the current study, but to caution that this rate appears to be a slight underestimate of the true rate of disability among all maltreated children.

A.2 Data Collection # 2

In Data Collection # 2, telephone interviews were conducted with CPS workers on a large sample of the substantiated cases of maltreatment that were included in Data Collection # 1.

A.2.1 Sampling

In this section, the sampling procedure used to select cases for inclusion in Data Collection 2 is discussed. To reduce respondent burden, a maximum of 5 interviews per

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caseworker was set. A sample of 5 cases was drawn in instances where a caseworker had responsibility for more than 5 cases.

An interval sampling procedure was used to draw the sample. The cases of each case worker who had more than 5 cases were assigned consecutive numbers beginning with the number "1." The interval was computed for each caseworker's cases by dividing the total number of cases by 5. For example, the interval for a caseworker's 7 cases was 7/5 or 1.4. Multiples of the interval, up to 5 times the interval, were also computed and rounded to the nearest whole number. To select cases, the assigned case numbers were matched to the five rounded multiples of the interval. For example, if the rounded multiples of the interval were 1, 3, 4, 6, and 7, the cases with these assigned numbers were selected.

To ensure that a sufficient number of cases with maltreated children with disabilities would be drawn, a higher probability of selection was given to cases where a known disability existed. Cases with a disability were given two assigned numbers rather than one.

A.2.2 Data Collection

Data Collection #2 consisted of followup telephone interviews with caseworkers on the same substantiated cases of child maltreatment that were reported by the CPS agencies during Data Collection #1. The purpose of this data collection was to:

- Update information on the diagnoses of disability;
- Update and refine information on the maltreatment, child, and family;
- Obtain information on the development of disabilities caused by the maltreatment;
- Identify the services, including prevention services, that have been planned and provided to date;
- Identify subsequent case actions or new reports of maltreatment of the child; and
- Obtain background information on the caseworker.

The interviews were conducted by telephone with the caseworker currently assigned to a given case or, if the case had been closed, with the last caseworker assigned to the case. The caseworkers were interviewed 90 -120 days after substantiation of the maltreatment.

A.2.2.1 Preparatory Contacts with Agencies

Prior to conducting data collection #2, several related activities took place. To obtain current information for conducting telephone interviews with caseworkers, Westat mailed the list of cases in the study to the participating agencies. The lists included the case number assigned by the agency; current or last case worker name and phone number; and the closing date, if the case was closed. Agencies revised the lists and returned them to Westat. The corrected information was added to the case file and used to prepare for Data Collection #2.

Approximately one month before data collection, letters describing the interview process and related materials were mailed to the agencies. The letter included "response lists" (i.e., list of responses to several of the closed-ended items in the questionnaire) for caseworkers to refer to during the interview so that interviews could be completed more quickly. Agencies were asked to distribute the response lists to the identified workers and inform them of the approved data collection arrangements. The mailing was followed by a phone call from senior project staff to determine if phone calls to caseworkers could begin.

A.2.2.2 Interviewer Training

Training of the telephone interviewers and their supervisors was conducted by senior project staff on June 4-5, 1991. A second training for 4 additional interviewers was held June 26 - 27, 1991. Training was held at Westat's Telephone Research Center. During training, interviewers received instruction on how to complete the various parts of the data collection instrument, how to answer caseworker questions, and procedures for scheduling. Following two days of intensive training, the interviewers began contacting caseworkers to explain the study and to schedule the interviews. During the scheduling calls, interviewers identified scheduling problems, such as cases that had been reassigned to other workers, and took steps to overcome these problems.

A.2.2.3 Data Collection Procedures and Results

Data collection took place over a 10 week period beginning July 6, 1991 and ending August 16, 1991. During data collection, an automated receipt control system was used to monitor the status of interviews. As completed forms were received, they were reviewed and the final disposition code entered into this system. Weekly reports were prepared on the number of interviews that were completed.

A total of 804 interviews were completed during the data collection period. This represented an overall response rate of 78 percent. Interviews were not conducted with one agency because approval to conduct the interviews was not obtained during the data collection period. In addition, some interviews could not be completed due to scheduling difficulties during the data collection period. For example, some cases had not been assigned to a case worker or had been transferred to an agency in another State. When an interview was not conducted, a disposition code was assigned indicating the reason why no interview was completed.

A.2.3 Data Processing

Soon after data collection was completed, a dBASE-IV system was developed that allowed responses to selected data items from the DC#2 data collection instrument to be entered directly into the system. The system was designed for use on personal computers.

Five data preparation operators (coders) and their supervisor were trained to use the system. Immediately following training, data entry began. The first 5-10 documents entered by each coder was spot checked by senior staff. When all data had been entered, 10 percent of each coder's work was randomly selected for thorough verification. A minimum of five documents were verified for each coder. When an unsatisfactory error rate was found, a further check was made. All errors were corrected in the data file.

Following the preliminary verification process, data were transferred to one datafile and a range check completed. Frequencies were produced on all variables for a final verification. Data from DC#1 were merged with the DC#2 data to create a new file for analyses. The updated information obtained during DC#2 was always used if there was a difference between that and data reported in DC#1. A SAS file was created from the d-BASE-IV file, which was then transferred to Westat's mainframe computer.

A.2.4 Weighting

The case weights constructed for Data Collection #1 were adjusted for subsampling of cases within agencies. A nonresponse adjustment was implemented in two steps. First, the weights were adjusted for case nonresponse within the agencies. In the second step, the case weights for the cooperating agencies in stratum 5 were adjusted for the refusal of one agency to participate in Data Collection #2 in this stratum. A nonresponse adjustment factor was computed as the ratio of the weighted sum of all eligible cases over the weighted sum of all completed cases in stratum 5. Then, the case weights in stratum 5 were multiplied by this adjustment factor.

For Data Collection #1, 36 replicate weights were constructed for variance estimation. The replicate weights for Data Collection #2 were obtained by applying the full sample weighting steps for Data Collection #2 to the Data Collection #1 replicate weights.

APPENDIX B

Instructions and Instrument for Data Collection #1

Note: To be consistent with P.L. 100-294, this instrument used the terms "handicaps" and "handicapping conditions." The body of this report uses the term "disabilities," which is the current terminology.

Form Approval
OMB No.: 0980-0214
Expires: December 31, 1991

A NATIONAL STUDY OF MALTREATMENT OF HANDICAPPED CHILDREN AND CHILD MALTREATMENT IN SUBSTANCE ABUSING FAMILIES

Data Collection #1

Time It Takes to Complete This Form

We estimate that it will take between 12 and 17 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form, write to the Office of Human Development Services, Attention: Reports Clearance Officer, Rm. 326-F, HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Paperwork Reduction Project, Washington, D.C. 20503.

Legislative Mandate

This study is being conducted under the mandate of Sections 102 and 103 of the Child Abuse Prevention, Adoption and Family Services Act of 1988 (P.L. 100-294).

Confidentiality

All of your answers will be kept completely confidential. Neither your name nor any other identifying information will appear on any report of the survey. Our only interest is in the combined answers from everyone who participates in the study.

Instructions

This package consists of four forms to be completed on recently substantiated cases of child maltreatment. By a "substantiated case," we mean a case for which a CPS investigation concluded that maltreatment occurred, even if services were never provided to individuals associated with the case. Please see your local data collection supervisor about how this definition applies to your agency.

The instructions on the following pages will assist you in completing these forms. In addition, a Glossary can be found at the end of the instrument to help clarify terms regarding child maltreatment, substance (alcohol or drug) abuse, and handicapping conditions. If you have any questions about how to complete a form, please call Scott Crosse at Westat, (301) 294-3979.

The forms are:

- FORM A: a form for recording information on the number and characteristics of each child in the household. (The pink form.)

- SUPPLEMENTAL FORM A: (attached to FORM A) to be completed for each child identified on FORM A as having a suspected or known handicap prior to the maltreatment. If you need additional SUPPLEMENTAL FORM A's, please see your local data collection supervisor. (The yellow form.)

- FORM B: a form for recording information on each adult who is in the family or a caretaker, or was involved in the maltreatment. (The blue form.)

- SUPPLEMENTAL FORM B: (attached to FORM B) to be completed for each adult identified on FORM B as having a suspected or known substance (alcohol or drug) abuse problem. If you need additional SUPPLEMENTAL FORM B's, please see your local data collection supervisor. (The green form.)

SUPPLEMENTAL FORM B: Suspected Alcohol or Drug Abuse

(To be completed for each adult with a suspected or known alcohol or drug abuse problem prior to the maltreatment.)

Enter case #: ______________________________

Enter adult's two digit code # (as found on FORM B, left-hand column): ________

Adult's first name: ____

1. What type of substance (alcohol or drug) abuse is suspected? (Circle all that apply. See Glossary for definitions and classifications of other drug terms.)

a.	Alcohol (beer, wine, liquor)	01
b.	Crack	02
c.	Cocaine	03
d.	Heroin	04
e.	Marijuana	05
f.	Sedatives (barbiturates, sleeping pills, Seconal, "downers")	06
g.	Tranquilizers (valium, librium, ativan, etc.)	07
h.	Analgesics (pain killers like Darvon, Demarol, Percodan, Tylenol with Codeine)	08
i.	Stimulants (amphetamines, Preludin, "uppers", speed)	09
j.	Inhalants (glue, amyl nitrite, "poppers", aerosol sprays)	10
k.	Hallucinogens (LSD, peyote, mescaline)	11
l.	PCP (angel dust)	12
m.	Illegally obtained methadone	13
n.	Abuses some type of drug -- not sure what type	14
o.	Other drug (specify) ______________________________	15

2. Write the letter of the one primary substance (alcohol or drug) that is suspected (i.e., the only one which causes the most harm or is used most frequently): ______

3. Circle the items below that describe the source(s) of information about the adult's alcohol or drug abuse. (Circle all that apply.)

a.	Police/sheriff	01
b.	Probation/corrections	02
c.	Coroner/medical examiner	03
d.	Social service agency	04
e.	School	05
f.	Day care	06
g.	Hospital/clinic/physician	07
h.	Mental health/alcohol or drug abuse treatment program	08
i.	Adult on whom completing form	09
j.	Your observations	10
k.	Family member	11
l.	Friend/neighbor/other individual	12
m.	Anonymous	13
n.	Other (specify) ______________________________	14

4. Write the letter of the one source of information above that you relied on the most: __________ **(If the letter is i. or j., please skip to Q9.)**

5. Does the source identified for Q4 base his/her belief on a medical or psychological assessment?

Yes	1
No	2
Don't know	8

6. Is it based on knowledge that the person has admitted alcohol or drug abuse, or has received treatment for an alcohol or drug abuse problem?

Yes	1
No	2
Don't know	8

7. Does the source have sufficient contact with the person to be aware of their use of alcohol or drugs?

Yes	1
No	2
Don't know	8

8. Does the source have any reason to be biased against the person (e.g., involved in custody dispute)?

Yes	1
No	2
Don't know	8

9. Overall, how reliable is the information on the alcohol or drug abuse problem from this source?

Very reliable	1
Somewhat reliable	2
Somewhat unreliable	3
Very unreliable	4

FORM A : Preliminary Case Information and Child Information

I. Preliminary Case Information

Item

1. **Case #**: Enter the agency's case record number.

2. **Worker Name:** Enter the name of the Protective Service Worker who investigated the case.

3. **Worker's Telephone #**: Enter the worker's telephone number.

4. **Agency Name:** Enter the agency's name.

5. **Date of Report**: Enter the date the maltreatment was reported.

6. **Date of Substantiation**: Enter the date the worker determined maltreatment to be substantiated or indicated.

7. **Referral Source:** This refers to the source of the initial allegation. Refer to codes directly on the form.

8. **Case Status:** This refers to the status of the case after it was substantiated. Refer to codes directly on form.

II. Child Information

9. **Child in Household**: List the first name only of each person in the household under the age of 18, beginning with the subject of the report. The subject is the oldest child for whom the maltreatment was substantiated. Then list all other children with substantiated allegations; then children with alleged, but unsubstantiated allegations; and then the children for whom there was no allegation. **If the perpetrator was a child, do not list him/her here. List him/her on Form B.**

10. **Relationship to Subject**: Refer to codes directly on form.

11. **Date of Birth**: Enter the date of birth of each child.

12. **Sex**: Enter the sex of each child.

13. **Ethnic Group:** Refer to codes directly on form.

14. **Child Role:** This refers to the child's involvement in the allegation. Refer to codes directly on the form.

15. **Type of Maltreatment:** Refer to codes directly on the form. Space is provided for you to enter up to three (3) types of maltreatment which were substantiated. If more than three types of maltreatment were substantiated, select the three which you consider to be the most serious.

See the Glossary for specific definitions of types of maltreatment.

16. **Suspected or Known Handicap**: For each child, indicate if there is any reason to believe that the child had a serious and chronic physical, mental, or emotional problem prior to the maltreatment. Children are considered to have a handicapping condition if they are evaluated as being mentally retarded; hard of hearing; deaf; speech impaired; visually handicapped; blind; seriously emotionally disturbed; orthopedically impaired; other health impaired; multihandicapped; or as having specific learning disabilities that limit functioning in one or more of the following life activities: mobility, self-care, receptive and expressive language, learning, self-direction, capacity for independent living, and economic self-sufficiency.

See the Glossary for specific definitions of types of handicapping conditions.

SUPPLEMENTAL FORM A: Suspected Handicapping Condition

Please fill out a SUPPLEMENTAL FORM A (the yellow form - attached to FORM A) for each child identified on FORM A as having a suspected or known handicapping condition prior to the maltreatment.

FORM B: Adult Information

Item

17. **Adults**: Enter the first name only of the mother or substitute. Then enter the name of the father or substitute if he/she is present in the home or involved in the maltreatment. Enter the names of other adults who have caretaking responsibilities for the child and/or were involved in the maltreatment incident. Enter the first name of the perpetrator whether or not he/she is a family member. **Even if the perpetrator was under the age of 18, list him/her on this form.**

18. **Relationship to the Child:** Refer to codes directly on the form.

19. **Caretaker Status:** Refer to codes directly on the form. Indicate which person is considered to have primary responsibility for the child who is the subject of the report. Only one person should be designated as the primary caretaker. Other adults who lived in the house or visited regularly may be considered other caretakers (e.g., a divorced parent not living in the household) if they

SUPPLEMENTAL FORM A: Suspected Handicapping Condition

(To be completed for each child with a suspected or known handicapping condition prior to the maltreatment.)

Enter seven digit Westat # (as found on label on FORM A): ___ - ______ - ___

Enter child's two digit code # (as found on FORM A, left-hand column): ______

Child's first name: ______________________________

1. Which types of handicapping conditions is the child suspected of having? (Circle all that apply. See Glossary for definitions and classifications of other conditions.)

a.	Mentally retarded (diagnosed)	01
	Developmentally delayed (undiagnosed)	
b.	Speech or language delayed	02
c.	Motor development delayed	03
d.	Orthopedically impaired	04
e.	Chronic health condition, (e.g., asthma, diabetes, cardiac problems)	05
f.	Hard of hearing (does not include problems correctable with a hearing aid)	06
g.	Deaf	07
h.	Visually handicapped (does not include problems correctable with glasses)	08
i.	Blind	09
j.	Speech or language impaired (diagnosed)	10
k.	Hyperactivity/attention deficit disorder	11
l.	Learning disabled	12
m.	Failure to thrive	13
n.	Seriously emotionally disturbed (if you circle this, please answer Q3 below)	14
	For children under one year of age	
o.	Low birthweight	15
p.	Positive drug or alcohol toxicology	16
q.	Premature	17
r.	HIV infected	18

2. Write the letter of the one type of handicap above that you would consider the most serious problem: ________

3. **If you circled item n. for Q1, please answer this question. Otherwise, skip to Q4.** Circle any of the following symptoms that the child has. (Circle all that apply. See Glossary for definitions and classifications of other conditions.)

a.	Suicide attempts	01
b.	Self-mutilation	02
c.	Eating disorders (e.g., anorexia, bulemia, pica)	03
d.	Bizarre behavior (e.g., talking to inanimate objects, growling)	04
e.	Bizarre language (e.g., persistent repeating of words, refusal to speak)	05
f.	Withdrawal, passivity	06
g.	Psychotic thought disorders	07
h.	Non-psychotic thought disorders	08
i.	Depression	09
j.	Lability and emotional instability (e.g., sharp mood swings)	10
k.	Phobias	11
l.	Sleep disturbance (e.g., sleepwalking, insomnia)	12
m.	Bedwetting/soiling	13
n.	Disorders in peer relations	14
o.	Disorders in relations with authority figures	15
p.	Other (specify) ____________________	16

4. Circle the items below that describe the source(s) of information about the child's condition. (Circle all that apply.)

a.	Police/sheriff	01
b.	Probation/corrections	02
c.	Coroner/medical examiner	03
d.	Social service agency	04
e.	School	05
f.	Day care	06
g.	Hospital/clinic/physician	07
h.	Mental health/alcohol or drug abuse treatment program	08
i.	Child on whom completing form	09
j.	Your observations	10
k.	Family member	11
l.	Friend/neighbor/other individual	12
m.	Anonymous	13
n.	Other (specify) ____________________	14

5. Write the letter of the one source of information above that you relied on the most: __________ **(If the letter is i. or j., please skip to Q11.)**

6. Does the source identified for Q5 have the professional knowledge to diagnose the condition?

Yes	1
No	2
Don't know	8

7. Did the source have the opportunity to examine, assess, or test the child's condition?

Yes	1
No	2
Don't know	8

8. Does the source have knowledge of previous diagnoses or tests?

Yes	1
No	2
Don't know	8

9. Had the source had sufficient contact with the subject to be aware of his/her physical, mental and emotional condition?

Yes	1
No	2
Don't know	8

10. Is there any reason to suspect the source has any bias or negative feelings about the child or family?

Yes	1
No	2
Don't know	8

11. Overall, how reliable is the information on the handicapping condition from this source?

Very reliable	1
Somewhat reliable	2
Somewhat unreliable	3
Very unreliable	4

FORM B

Case #:____________________

Adult Information

Please provide information on each adult who is in the family or a caretaker, or was involved in the maltreatment. Even if the perpetrator was under the age of 18, provide information on him/her on this form. For cases with more than six adults, please continue on an additional Form B; please copy the Westat # (on the top of this form) to the top of any additional forms.

(17) Adult	(18) Relationship to child (see codes)	(19) Caretaker status (see codes)	(20) Alleged role (see codes)	(21) Age in years	(22) Sex (M or F)	(23) Ethnic group (see codes)	(24) Suspected or known alcohol or drug abuse prior to maltreatment (Y or N)
01 Mother/substitute ____________________							
02 Father/substitute ____________________							
03 Other involved adults ____________________							
04 ____________________							
05 ____________________							
06 ____________________							

Codes

18. Relationship to the child
For each adult listed, enter the code indicating that person's relationship to the child who is the subject of the report:
    1. Biological mother
    2. Adoptive mother
    3. Stepmother
    4. Foster mother
    5. Biological father
    6. Adoptive father
    7. Stepfather
    8. Foster father
    9. Grandparent
    10. Aunt/uncle
    11. Sibling
    12. Other relative (specify) ____________________
    13. Parent's girl/boy friend
    14. Other adult (specify) ____________________
    98. Don't know

19. Caretaker status
For each adult listed, enter the code indicating that person's caretaker status with regard to the child who is the subject of the report:
    1. Primary caretaker
    2. Other caretaker
    3. Not a caretaker
    8. Don't know

20. Alleged role
Enter the appropriate code for each adult listed:
    1. Maltreated the child
    2. Permitted maltreatment
    3. No involvement
    8. Don't know

23. Ethnic group
Enter the race/ethnicity of each adult listed:
    1. American Indian/Alaska Native
    2. Asian
    3. Black, not Hispanic
    4. Hispanic
    5. White, not Hispanic
    6. Other (specify) ____________________
    8. Don't know

APPENDIX C

Glossary of Terms Relating to Child Maltreatment, Drug and Alcohol Abuse and Disabilities

Note: To be consistent with P.L. 100-294, this glossary used the terms "handicaps" and "handicapping conditions." The body of this report uses the term "disabilities," which is the current terminology.

KEY DEFINITIONS

The following are three key definitions used in this study. Detailed definitions regarding specific types of child maltreatment, drug and alcohol abuse and handicapping conditions follow.

Child Maltreatment: Situations where, through purposive acts or extreme inattention to the child's needs, behavior of a parent/substitute or other adult known to the child causes foreseeable and avoidable injury or impairment to a child or contributes to the unreasonable prolongation or worsening of an existing injury or impairment. Also includes situations that seriously endanger the child's physical, mental or emotional health or well-being. Examples are attempted, threatened, or potential physical or sexual assault; extreme lack of supervision of an infant or young child; dangerous or unhygienic living conditions due to extreme parental inattention; or other situations where extreme inattention or purposive acts conspicuously endanger a child's health or safety.

Drug and alcohol abuse: These terms are defined below:

- **Drug Abuse:** The recreational use of any illegal drug, even if no harm occurs to the individual, their family, or society. Also, the illicit use of other drugs that can be legally obtained, such as prescription drugs.
- **Alcohol Abuse:** Alcohol abuse is defined generally as any use of alcoholic beverages that causes negative social or personal consequences such as arrest, accident involvement, health problems, impairment of job performance, or difficulties in personal relationships. Alcoholism is defined as a chronic and progressive disease, characterized by a dependence on alcohol, and by consumption of alcoholic beverages sufficiently great and consistent to cause physical, mental, social or economic disability.

Handicapping Condition: Children are considered to have a handicapping condition if they are evaluated as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, blind, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multihandicapped, or as having specific learning disabilities, who because of those impairments, have limited functioning in one or more of the following life activities: mobility, self-care, receptive and expressive language, learning, self-direction, capacity for independent living, and economic self-sufficiency.

COMMON TERMS RELATING TO CHILD MALTREATMENT

This glossary lists common terms regarding child maltreatment, and will direct you to the category under which each term should be coded. For example, a maltreatment incident involving inadequate clothing should be coded as physical neglect. The terms are alphabetically arranged.

Abandonment: Desertion of a child without arranging for reasonable care and supervision. Can include cases where children are not claimed within 2 days, and where children were left by parents/substitutes who gave no (or false) information about their whereabouts.

Assault: See Physical Assault.

Binding: See Emotional Abuse.

Confinement: See Emotional Abuse.

Custody: See Expulsion/Other Custody Issues.

Desertion: See Abandonment.

Drug/Alcohol Abuse (Permitted): See Other Emotional Neglect.

Emotional Abuse: This type of abuse can be one of three types:

- Close confinement--Tortuous restriction of movement, as by tying a child's arms or legs together or binding a child to a chair, bed or other object, or confining a child to an enclosed area (such as a closet) as a means of punishment.

- Verbal or Emotional Assault-- Habitual patterns of belittling, denigrating, scapegoating, or other nonphysical forms of overtly hostile or rejecting treatment, as well as threats of other forms of maltreatment, such as threats of beating, sexual assault, abandonment, and so on.

- Other or Unknown Abuse--Overtly punitive, exploitative, or abusive treatment other than those specified under other forms of abuse, or unspecified abusive treatment. This form includes attempted or potential physical or sexual assault (where actual physical contact did not occur; e.g., throwing something at the child), deliberate withholding of food, shelter, sleep, or other necessities as a form of punishment, economic exploitation, and unspecified abusive actions.

Emotional Assault: See Emotional Abuse.

Expulsion/Other Custody Issues: Blatant refusals of custody, such as permanent or indefinite expulsion of a child from the home without adequate arrangement for care by others, or refusal to accept custody of a returned runaway. Other custody issues include forms of inattention to child's needs other than those covered by abandonment or expulsion, such as shuttling a child from one household to another due to apparent unwillingness to maintain custody, or chronically and repeatedly leaving a child with others for days/weeks at a time.

Failure to Register for School: See Other Educational Neglect.

Failure to Thrive: See Physical Neglect and/or Inadequate Nurturance.

Fondling: See Sexual Abuse.

General Maltreatment: See Other Maltreatment.

Inadequate Clothing: See Physical Neglect.

Inadequate Hygiene: See Physical Neglect.

Inadequate Nurturance/Affection: Marked inattention to the child's needs for affection, emotional support, attention or competence.

Inadequate Nutrition: See Physical Neglect.

Inadequate Supervision: Child left unsupervised or inadequately supervised for extended periods of time or allowed to remain away from home overnight without parent/substitute knowing (or attempting to determine) the child's whereabouts.

Inattention to Special Educational Need: Refusal to allow or failure to obtain recommended remedial educational services, or neglect in obtaining or following through with treatment for a child's diagnosed learning disorder or other special education need without reasonable cause.

Medical Neglect: Refusal or delay in providing or allowing needed care for a physical injury, illness, medical condition or impairment in accord with recommendations of a competent health care professional, or which any reasonable layman would have recognized as needing professional medical attention.

Molestation: See Sexual Abuse.

Other Educational Neglect: Permitted chronic truancy, averaging at least five days a month, if the parent was informed of the problem and had not attempted to intervene. Also, failure to register or enroll a child of mandatory school age, causing the child to miss at least one month of school, or a pattern of keeping a child home for nonlegitimate reasons (e.g., to work, care for siblings, etc.) an average of at least three days a month.

Other Emotional Neglect: This category can include several types:

- Chronic or extreme spouse abuse or other domestic violence in the child's presence.
- Encouragement or permitting of drug or alcohol use by the child; especially if it appeared that the parent/guardian had been informed of the problem and had not attempted to intervene.
- Encouragement or permitting of other maladaptive behavior (e.g., severe assaultiveness, chronic delinquency) under circumstances where the parent/guardian had reason to be aware of the existence and seriousness of the problem but did not attempt to intervene.
- Other inattention to the child's developmental/emotional needs not classifiable under any of the above forms of emotional neglect (e.g., markedly overprotective restrictions which foster immaturity or emotional overdependence, chronically applying expectations clearly inappropriate in relation to the child's age or level of development, etc.)

Other Maltreatment: This category includes several components:

- General or Unspecified Neglect: Used for neglect allegations not classifiable elsewhere, for lack of preventive health care, and for unspecified forms of neglect or multiple neglect allegation.
- Other or Unspecified Maltreatment: Problems/allegations not classified elsewhere. These include maltreatment not specified as having involved abuse, neglect or both; parent/substitute problems (such as alcoholism, prostitution, drug abuse) alleged to affect the child in unspecified ways, etc.

Overprotectiveness: See Other Emotional Neglect.

Physical Abuse: See Physical Assault.

Physical Assault: Any assault (including excessive corporal punishment) resulting in bodily injury with symptoms lasting at least 48 hours in observable form (slight bruising or reddening of the skin consistent with mild corporal punishment is excluded).

Physical Neglect: Conspicuous inattention to avoidable hazards in the home; inadequate nutrition, clothing, or hygiene; and other forms of reckless disregard of the child's safety and welfare, such as driving with the child while intoxicated, leaving a young child unattended in a motor vehicle, and so forth.

Refusal or Delay of Psychological Care: Refusal to allow or failure to seek or provide needed treatment for a child's emotional or behavioral impairment or problem in accord with a competent professional recommendation, or which any reasonable layman would have recognized as needing professional attention (e.g., severe depression, suicide attempt).

Sexual Abuse: This form of abuse can be one of three types:

- Intrusion-- Evidence of actual penile penetration--whether oral, anal or genital, homosexual or heterosexual.
- Molestation with Genital Contact-- This involves acts where some form of actual genital contact has occurred, but where there was no specific indication of intrusion.
- Other Unknown Sexual Abuse-- Unspecified acts not known to have involved actual genital contact (e.g., fondling of breasts or buttocks, exposure) and for allegations concerning inadequate or inappropriate supervision of a child's voluntary sexual activities.

Spouse Abuse: See Other Emotional Neglect.

Throwaway: See Expulsion.

Truancy: See Other Educational Neglect.

Tying Up: See Emotional Abuse.

Verbal Assault: See Emotional Abuse.

COMMON TERMS RELATING TO DRUG AND ALCOHOL ABUSE

This glossary lists common terms relating to drug and alcohol abuse and will direct you to the category under which each term should be coded. The terms are alphabetically arranged.

Aerosol Sprays: See Inhalants.

Alcohol:

- Any beverage that contains ethyl alcohol (ethanol), the intoxicating sedative-hypnotic in fermented and distilled liquids.
- At low doses it can act as a stimulant; at high doses it can create a stupor. Alcoholic beverages are usually classified into the fermented drinks **beer** and **wine**, and distilled spirits (**liquor**).
- Slang names: Booze, juice.

Amphetamines: See Stimulants.

Amyl Nitrite: See Inhalants.

Analgesics:

- A major class of drugs that produce relief from pain without loss of consciousness.
- Can be taken orally in the form of pills, or injected, or smoked.
- Includes aspirin, Darvon, Demarol, Tylenol with Codeine, Percodan, Dilaudid, or opiate narcotics, such as opium or morphine.

Aspirin: See Analgesics.

Ativan: See Tranquilizers.

Barbiturates: See Sedatives.

Bernice: See Cocaine.

Booze: See Alcohol.

Brown Sugar: See Heroin.

Cocaine:

- A powdered substance refined from the coca plant that is a short-acting but powerful stimulant.
- Cocaine is usually inhaled through the nose, or rubbed on the gums.
- Slang names: Corrine, coke, Bernice, flake, star dust, snow.

Coke: See Cocaine.

Corrine: See Cocaine.

Crack:

- A form of cocaine that has been chemically altered so it can be smoked.
- The drug belongs to a category of drugs known as freebase. When heated, the mixture makes a cracking sound.
- Crack looks like small lumps of soap shavings. Some lumps of crack are called rocks.

Darvon: See Analgesics.

Demarol: See Analgesics.

Dilaudid: See Analgesics.

Dolly: See Methadone.

DOM: See Hallucinogens.

Doriden: See Tranquilizers.

Downers: See Sedatives.

Equanil: See Tranquilizers.

Flake: See Cocaine.

Glue: See Inhalants.

Grass: See Marijuana.

H: See Heroin.

Hallucinogens:

- A major drug category of natural and synthetic drugs whose primary effect is to distort the senses; they can produce hallucinations--experiences that depart from reality. Also known as psychedelic drugs.
- Hallucinogens are usually taken orally.
- Includes LSD, peyote, mescaline, PCP, STP, and DOM.

Harry: See Heroin.

Hash (or hashish): See Marijuana.

Heroin:

- Heroin, a narcotic, is a semi-synthetic opiate derivative.
- Heroin is usually injected.
- Slang names: H, horse, scat, junk, smack, scag, stuff, Harry, brown sugar.

Horse: See Heroin.

Inhalants:

- A class of depressant drugs (generally gases) that are usually inhaled and whose effects are usually short-lived.
- Inhalants include glue, amyl nitrite, nitrous oxide, "poppers", and aerosol sprays.

Juice: See Alcohol.

Junk: See Heroin.

Librium: See Tranquilizers.

LSD: See Hallucinogens.

Marijuana:

- A drug derived from different varieties of the Cannabis plant.
- Marijuana is usually smoked (cigarette or dry pipe) or eaten (solid or liquid preparations).
- Slang terms: pot, grass, weed, joint (marijuana cigarette).

Mescaline: See Hallucinogens and PCP.

Methadone:

- An opium compound used in the treatment of heroin dependency.
- It is taken orally and prevents heroin withdrawal symptoms, but is itself addictive.
- Slang name: Dolly.

Morphine: See Analgesics.

Nitrous Oxide: See Inhalants.

Opiate Narcotics: See Analgesics.

Opium: See Analgesics.

Paranoid Syndrome: See Cocaine.

PCP (angel dust):

- A synthetic depressant drug sold on the street as a hallucinogen.
- Usually smoked, and may be added to marijuana.
- Other names for PCP are THC, mescaline, or psilocybin.

Percodan: See Analgesics.

Peyote: See Hallucinogens.

Poppers: See Inhalants.

Pot: See Marijuana.

Preludin: See Stimulants.

Psilocybin: See PCP.

Psychedelic Drugs: See Hallucinogens.

Quaaludes: See Tranquilizers.

Rocks: See Crack.

Scag: See Heroin.

Scat: See Heroin.

Seconal: See Sedatives.

Sedatives:

- A major class of non-narcotic depressant drugs with such primary effects as calming, sedation, or inducing sleep (hypnosis).
- Sedatives are usually taken orally.
- Include barbiturates, sleeping pills, Seconal, or "downers".

Sleeping pills: See Sedatives.

Smack: See Heroin.

Snow: See Cocaine.

Speed: See Stimulants.

Star Dust: See Cocaine.

Stimulants:

- A major class of drugs that may produce euphoria, sleeplessness, increased mental activity, energy, and loss of appetite.
- Stimulants are usually taken orally in the form of pills.
- Include amphetamines, "uppers", speed, and Preludin.

STP: See Hallucinogens.

Stuff: See Heroin.

THC: See PCP.

Tranquilizers:

- A group of drugs that have a depressant effect, relieve anxiety and tension, and sometimes relax muscles.
- Usually taken orally or by injection, and are widely prescribed. They produce effects similar to alcohol and barbiturates and are often used non-medically.
- Tranquilizers include Valium, Librium, Ativan, Equanil, Quaaludes and Doriden.

Tylenol with Codeine: See Analgesics.

Uppers: See Stimulants.

Valium: See Tranquilizers.

Weed: See Marijuana.

COMMON TERMS RELATING TO HANDICAPPING CONDITIONS

This glossary lists common terms relating to handicapping conditions, and will direct you to the category under which each term should be coded. The terms are alphabetically arranged.

AIDS: See HIV Infected.

Amplification: See Deaf.

Amputation: See Orthopedically Impaired.

Anorexia Nervosa: See Eating Disorders.

Attention Deficit Disorder: See Hyperactivity.

Autism: See Chronic Health Condition.

Bedwetting/Soiling: Involuntary voiding of urine, not due to physical disorder, after a mental age at which continence is expected.

Bizarre Behavior:

- Incidents that are exceptionally abnormal, unusual, or peculiar.
- Can include oddities of movement (finger-snapping, toe walking), growling or barking, talking to inanimate objects, autistic-type self-stimulatory behavior like continual spinning or rocking or an unusual preoccupation with objects.

Bizarre Language:

- Peculiar or abnormal speech patterns not resulting from a speech disorder.
- Can include echolalia (repetition of words or phrases of others), perseveration (persistent repeating of words), neologisms (invented or distorted word meanings), or elective mutism (refusal to speak).

Blindness:

- Child is sightless or has such limited vision that he/she must rely on hearing and touch as the chief means of learning; or
- A determination of legal blindness in the state of residence has been made.

Brain Injury: See Learning Disabled.

Bulimia: See Eating Disorders.

Burns: See Orthopedically Impaired.

Cerebral Palsy: See Orthopedically Impaired; see also Speech or Language Impaired.

Chronic Health Condition:

- Having limited strength, vitality or alertness, due to chronic or acute health problems which adversely affect a child's functioning in one or more life activities.
- Conditions include: heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes.
- Children diagnosed as autistic are included in this category.

Cleft Palate: See Speech or Language Impaired.

Clubfoot: See Orthopedically Impaired.

Communication Disorder: See Speech or Language impaired.

Deaf:

- A hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification.
- Impairment adversely affects a child's functioning in one or more life activities.
- Legal determination of deafness in the state of residence.

Deaf and Blind:

- Both hearing and visual impairments.
- May have severe communication problems.
- May have serious developmental problems.
- Adversely affects a child's functioning in one or more life activities.

Delusions: See Psychotic Thought Disorders.

Depression:

- Abnormal and persistent low spirits or gloominess.
- Loss of interest or pleasure in usual activities; loss of energy or fatigue; poor appetite or significant weight loss; increased appetite or significant weight gain; difficulty in sleeping or excessive sleeping; feelings of worthlessness, self-reproach or excessive or inappropriate guilt; complaints or evidence of diminished ability to think or concentrate; recurrent thought of death, suicide, or wish to be dead.
- Does not include normal periods of "the blues" or normal grief or sadness associated with a specific event, such as the death of a loved one.

Developmental Aphasia: See Learning Disabled.

Developmentally Delayed: Can be either of the following:

- Speech or Language Delayed:
    - An undiagnosed condition in children under 5 years of age in which speech or language development appears substantially less than expected for a child that age.
    - May indicate a health problem or retardation but no such diagnosis exists.
- Motor Development Delayed:
    - An undiagnosed condition in children under 5 years of age in which physical growth, coordination, and motor skills development appear substantially less than expected for a child that age.
    - May indicate a health problem or retardation but no such diagnosis exists.

Diabetes: See Chronic Health Condition.

Disorders in Peer Relations:

- Serious impairment in ability to relate to other children.
- Little or no interest in making friends, extreme shyness, isolation, extreme anxiety in social situations, or persistent victimization of others; exploitation of others with no concern for them; aggression.

Disorders in Relations with Authority Figures:

- Inability to establish normal relationship with teachers, program staff, or other adults.
- Includes aggression.

Dyslexia: See Learning Disabled.

Eating Disorders: Includes the following:

- Pica (eating non-food items).
- Bulimia (serious binge eating accompanied by episodes of starving, induced vomiting, etc.).
- Anorexia nervosa (serious self-starvation to the extent that life may be threatened).

Echolalia: See Bizarre Language.

Emotionally Disturbed: See Seriously Emotionally Disturbed.

Epilepsy: See Chronic Health Condition.

Failure to Thrive:

- A medical condition seen in infants and children who are not making normal progress in physical growth, falling below the mean height or weight for their age and sex.
- Causes of failure to thrive may be physiological but can also be the result of environmental and interpersonal factors.

Fears: See Phobias.

Glasses: See Visually Handicapped.

Gloominess: See Depression.

Hallucinations: See Psychotic Thought Disorders.

Hard of Hearing:

- A hearing impairment, whether permanent or fluctuating, which adversely affects a child's functioning in one or more life activities, but which is not included under the definition of "deaf" for this section.
- Slightly to severely defective hearing, as determined by ability to use residual hearing in daily life.

Heart Condition: See Chronic Health Condition.

Hemophilia: See Chronic Health Condition.

HIV Infected: Infants testing positive for the human immunodeficiency virus -- AIDS (HIV, also called HTLV-III and LAV).

Human Immunodeficiency Virus (HIV): See HIV Infected.

Hyperactivity/Attention Deficit Disorder:

- Excessive or frenzied physical activity in constant motion and not goal-directed.
- Substantially impaired ability to pay attention as evidenced by extreme distractibility, difficulty concentrating on schoolwork or other tasks requiring sustained attention; frequent failure to complete a task.
- Children believed to have this disorder are often taking a drug called Ritalin.

Infant Drug Addiction: See Alcohol/Drug Toxicology.

Infant Alcohol Addiction: See Alcohol/Drug Toxicology.

Insomnia: See Sleep Disturbance.

Isolation: See Disorders in Peer Relations.

Lability and Emotional Instability:

- Sharp swings or rapid, repeated and abrupt shifts in interpersonal behavior, mood, self-image or attitude.
- Appear to have little or no relationship to environment.

Lead Poisoning: See Chronic Health Condition.

Learning Disabled:

- Children without other disabilities who show severe difficulties in understanding or using language (spoken or written), listening, thinking, reading, writing, spelling, or doing math.
- Adversely affects a child's functioning in one or more life activities.
- For preschool children, precursor functions to understanding and using language (spoken or written), and computing or reasoning abilities are included.
- Perceptual handicaps.
- Brain injury.
- Minimal brain dysfunction.

- Dyslexia (difficulty processing reading).
- Developmental aphasia (difficulty processing language).
- Does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

Learning Disorder: See Learning Disabled.

Leukemia: See Chronic Health Condition.

Life Activities: See Handicapping Condition.

Low Birthweight: A baby weighing 5 pounds, 8 ounces or less at birth is considered "low birthweight".

Manic Depressive: See Psychotic Thought Disorders.

Mentally Retarded:

- Significantly sub-average intellectual functioning that exists along with deficits in adaptive behavior.
- Manifested during the developmental period.
- Adversely affects a child's functioning in one or more life activities.

Minimal Brain Dysfunction: See Learning Disabled.

Mood Swings: See Lability and Emotional Instability.

Mutism: See Bizarre Language.

Nightmares: See Sleep Disturbance.

Non-Psychotic Thought Disorders:

- Serious distortion of reality, but not so gross as to be psychotic.
- Includes magical thinking, belief in clairvoyance, telepathy, recurrent illusions, grandiosity, or belief in importance or special meaning of an event, object or individual; paranoid tendencies.

Orthopedically Impaired:

- A severe orthopedic impairment which adversely affects a child's functioning in one or more life activities.
- Includes impairments caused by:
  - Congenital anomaly (e.g., clubfoot, absence of some member),
  - A disease (e.g., poliomyelitis, bone tuberculosis),
  - Impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures).

Paranoia: See Psychotic Thought Disorders.

Passivity: See Withdrawal.

Perceptual Handicaps: See Learning Disabled.

Perinatal Infant: An infant during the period from several months before birth to 30 days after birth.

Perseveration: See Bizarre Language.

Phobias: Excessive and unusual specific fears that interfere with daily functioning.

Pica: See Eating Disorders.

Polio: See Orthopedically Impaired.

Positive Drug or Alcohol Toxicology: An infant testing positive for drugs or alcohol at birth.

Premature: Birth occurring before the 38th week of pregnancy.

Psychotic Thought Disorders:

- Gross impairment in reality testing not attributable to mental retardation.
- Includes hallucinations (seeing or hearing things that aren't there); bizarre delusions (false belief that is patently absurd); marked losing of associations (thinking that shifts from one subject to a completely unrelated topic); marked illogical thinking.

Rheumatic Fever: See Chronic Health Condition.

Ritalin: See Hyperactivity.

Schizophrenia: See Psychotic Thought Disorders.

Self-Mutilation:

- Intentional physical actions that are physically harmful to child.
- Includes activities such as slapping or hitting self, head banging, hair pulling, scratching or biting self, putting hand through a window, etc.
- Do not include suicide attempts here.

Seriously Emotionally Disturbed: A condition existing over a long period of time that may indicate the child is:

- Dangerously aggressive toward others.
- Self-destructive.
- Severely withdrawn and noncommunicative.
- Hyperactive to the extent that it affects adaptive behavior.
- Severely anxious.
- Depressed or phobic.
- Psychotic.
- Adversely affects a child's functioning in one or more life activities.

Shyness: See Disorders in Peer Relations.

Sickle Cell Anemia: See Chronic Health Condition.

Sleep disturbance: Nightmares, insomnia, sleepwalking.

Sleepwalking: See Sleep Disturbance.

Speech or Language Impaired (diagnosed):

- A communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment which adversely affects a child's functioning in one or more life activities.
- May accompany such conditions as hearing loss, cleft palate, cerebral palsy, mental retardation, emotional disturbance, and other sensory and health impairments.

Suicide Attempts: Child has made overt suicide threats, gestures, or attempts, beyond mere attention-getting, talk, or ideation.

Tuberculosis: See Chronic Health Condition.

Visually Handicapped (does not include problems correctable with glasses): A visual impairment which, even with correction, adversely affects a child's functioning in one or more life activities; e.g., faulty muscular action.

Withdrawal, Passivity:

- Lack of responsiveness to surroundings.
- Does not respond to direct questions.
- Isolates self from others.
- Out of touch with others or environment.

APPENDIX D

Instrument for Data Collection #2

Note: To be consistent with P.L. 100-294, this instrument used the terms "handicaps" and "handicapping conditions." The body of this report uses the term "disabilities," which is the current terminology.

Form Approval
OMB No.: 0980-0214
Expires: December 31, 1991

A NATIONAL STUDY OF MALTREATMENT OF HANDICAPPED CHILDREN AND CHILD MALTREATMENT IN SUBSTANCE ABUSING FAMILIES

Data Collection #2
Telephone Survey

(Administered 90 days after Data Collection #1)

CASE SUMMARY

	Child 1 ______	Child 2 ______	Child 3 ______	Child 4 ______	Child 5 ______	Child 6 ______
Row 1 Substantiated Maltreatment	☐	☐	☐	☐	☐	☐
Row 2 Handicapping Condition	☐	☐	☐	☐	☐	☐

BOX 1
Are there any additional Child Update sheets?
Yes.................. (GO TO NEXT ONE)
No.................. Check Substantiated Maltreatment row above. Is there at least one child whose maltreatment is substantiated?
Yes.................... (GO TO FIRST ADULT UPDATE SHEET)
No..................... (TERMINATE)

	Adult 1 ______	Adult 2 ______	Adult 3 ______	Adult 4 ______	Adult 5 ______	Adult 6 ______
Row 3 Perpetrator	☐	☐	☐	☐	☐	☐
Row 4 Permitted Maltreatment	☐	☐	☐	☐	☐	☐
Row 5 Primary Caretaker	☐	☐	☐	☐	☐	☐
Row 6 Other Caretaker	☐	☐	☐	☐	☐	☐
Row 7 Substance Abuse	☐	☐	☐	☐	☐	☐

BOX 2
Are there any additional Adult Update sheets?
Yes..................... (GO TO NEXT ONE)
No...................... (GO TO Q16)

BOX 3
Is there more than one primary caretaker?
Yes..................... SAY TO RESPONDENT "You have identified (NAMES) as primary caretakers. For our study, we'd like to call just one individual the primary caretaker of the child who is the subject of this report. Which one person would you say is best to consider a primary caretaker?" (MAKE CHANGES ON CASE SUMMARY FOR ADULTS CHANGED FROM PRIMARY TO OTHER CARETAKER.)
No..................... GO TO PART 2

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PART 1: VERIFICATION AND UPDATE OF PRELIMINARY DATA

Hello, my name is ____________________ from Westat Research in Rockville, Maryland.
May I please speak with (NAME OF RESPONDENT)?

IF GATEKEEPER ASKS FOR MORE INFORMATION: _________ is participating in a study with us and is expecting our phone call.

IF NO: When would be the best time to reach him/her? [RECORD ON CALL RECORD].

IF YOU ARE ASKED WHETHER YOU'D LIKE TO LEAVE A MESSAGE, SAY: I'll be happy to call him/her back at a more convenient time. When would be the best time to reach him/her?

REPEAT INTRODUCTION IF SOMEONE OTHER THAN RESPONDENT ANSWERS THE TELEPHONE.

As you know, I'm calling to interview you about case number ___________ (AGENCY CASE NUMBER) for the National Study of Maltreatment of Handicapped Children and Child Maltreatment in Substance Abusing Families.

Before we start, let me tell you a little about this interview and study.

- We estimate that it will take about 30-45 minutes to complete this interview.
- This study is being conducted under the mandate of Sections 102 and 103 of the Child Abuse Prevention, Adoption, and Family Services Act of 1988 (P.L. 100-294).
- All of your answers will be kept completely confidential. Neither your name nor any other identifying information will appear in any report of the survey. Our only interest is in the combined answers from everyone who participates in the study.

For this interview, you will probably need to consult your case files. In addition, it will be easier and faster if you have the response listings which we sent to your agency. Do you have the case file and response listings handy now?

YES________________ (CONTINUE)
NO_________________ I can hold while you get that material or, if you prefer, I can call back in about 5 minutes.

Hold ______________ (WAIT UNTIL RESPONDENT IS READY)
Callback___________ I'll call back at this number (READ TELEPHONE NUMBER) in 5 minutes. (WHEN CALLING BACK, REPEAT INTRODUCTION, THEN SKIP TO THIS POINT.)

Throughout this interview we will use the term "substantiated maltreatment." Some agencies have other terminology such as confirmed, indicated or supported to describe the results of the agency's investigation. For the purposes of this study, we'd like you to include as substantiated any instance in which the agency has concluded maltreatment occurred, even if services were never provided to individuals associated with the case.

First, I'd like to check the information that we have for this case. In the course of an investigation I understand that you often receive new information; we'd like to make sure our records are up-to-date.

1a. According to my records, the date this case was reported to your agency is ___/___/___.
Is that correct? ______________________________ Y N → [___/___/___]
(CIRCLE YES OR NO. IF NO, ENTER CORRECT DATE IN BRACKETED AREA. ENTER MONTH/DAY/YEAR.)

1b. The date of substantiation is ___/___/___.
Is that correct? ______________________________ Y N → [___/___/___]
(CIRCLE YES OR NO. IF NO, ENTER CORRECT DATE IN BRACKETED AREA. ENTER MONTH/DAY/YEAR.)

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CHILD UPDATE

Child # ____________

The children in the household are as follows:

1. First/next is ____________________ .... Y N → [______________]

who is Male/Female .... Y N → [Male/Female]

and was born in 19 __ __ .... Y N → [19 __ __]

Is that correct? (CIRCLE YES OR NO FOR EACH ITEM; IF NO, ENTER CORRECTION IN BRACKETED FIELDS.)

S/he is:
1. A substantiated victim of maltreatment .... [1] (Row 1)
2. An alleged victim .... [2]
3. Not involved .... [3]
8. Don't know child's role .... [8]

Is that correct? (IF YES, CIRCLE ORIGINAL INFORMATION IN BRACKETED FIELDS; IF NO, CIRCLE CORRECT INFORMATION IN BRACKETED FIELDS AND REPEAT ALOUD.)

2. (REFER RESPONDENT TO LIST 1.) The preliminary report indicates that prior to maltreatment:

A.___S/he did have a known or suspected handicapping condition. List 1 lists the handicapping conditions so you can see what we mean by that. .... [1. (Q3)] (Row 2) did have [2. (Q6)] did not have

B.___S/he did not have a known or suspected handicapping condition. List 1 lists the handicapping conditions so you can see what we mean by that. .... [1. (Q7)] (Row 2) did have [2.(BOX 1)] did not have

Is that correct? (MARK: Did or did not have handicap.)

3. (REFER RESPONDENT TO LIST 1) The handicapping conditions the child is suspected of having are:

1. Mentally retarded (diagnosed) ____________ [01]
2. Speech or language development delayed ______ [02]
3. Motor development delayed ____________ [03]
4. Orthopedically impaired ____________ [04]
5. Chronic health condition, (e.g., asthma, diabetes, cardiac problems) ____________ [05]
6. Hard of hearing (does not include problems correctable with a hearing aid) ______ [06]
7. Deaf ____________ [07]
8. Visually handicapped (does not include problems correctable with glasses) ______ [08]
9. Blind ____________ [09]
10. Speech or language impaired (diagnosed) ______ [10]
11. Hyperactivity/attention deficit disorder ______ [11]
12. Learning disabled ____________ [12]
13. Low birthweight ____________ [13]
14. Positive drug or alcohol toxicology ______ [14]
15. Premature ____________ [15]
16. Failure to thrive ____________ [16]
17. HIV infected ____________ [17]
18. Seriously emotionally disturbed ______ [18]

Is that correct? (IF YES, COPY ANSWERS TO BRACKETED FIELDS; IF NO, CIRCLE CORRECT ANSWERS IN BRACKETED FIELDS AND VERIFY ALOUD.)

BOX 2
Is there more than one answer to Q3?
YES ______________ (Q4)
NO ______________ (BOX 1)

4. Which of the handicapping conditions would you say is the primary or most serious one? (WRITE NUMBER IN BRACKETS) ______ [__ __]

BOX 3
Is Q3 = 18 seriously emotionally disturbed?

YES ________ (Q5)
NO ________ (BOX 1)

5. (REFER RESPONDENT TO LIST 2) The child has the following symptoms:/(Does the child have any of the following symptoms?)

1.	Suicide attempts	[01]
2.	Self-mutilation	[02]
3.	Eating disorders (e.g., anorexia, bulemia, pica)	[03]
4.	Bizarre behavior (e.g., talking to inanimate objects, growling)	[04]
5.	Bizarre language (e.g., persistent repeating of words, refusal to speak)	[05]
6.	Withdrawal, passivity	[06]
7.	Psychotic thought disorders	[07]
8.	Non-psychotic thought disorders	[08]
9.	Depression	[09]
10.	Lability and emotional instability (e.g., sharp mood swings)	[10]
11.	Phobias	[11]
12.	Sleep disturbance (e.g., sleepwalking, insomnia)	[12]
13.	Bedwetting/soiling	[13]
14.	Disorders in peer relations	[14]
15.	Disorders in relations with authority figures	[15]
16.	Other (specify) ________	[16]

GO TO BOX 1

6. What is the reason that you no longer suspect that (CHILD'S NAME) had a handicapping condition prior to the maltreatment?

Medical Report found no handicap	1
School report/teacher indicated no handicap	2
Psychological assessment indicated child had no handicap	3
Continued observation of the child indicates no handicap	4
Additional information provided by parent/caretaker suggests child had no handicapping condition	5
Handicap did not exist prior to maltreatment but was a result of the maltreatment	6
Other (specify) ________	7

GO TO BOX 1

7. (ASK RESPONDENT TO REFER TO LIST 1.) Which types of handicapping conditions is the child suspected of having? (CIRCLE ALL THAT APPLY.)

1.	Mentally retarded (diagnosed)	01
2.	Speech or language development delayed	02
3.	Motor development delayed	03
4.	Orthopedically impaired	04
5.	Chronic health condition, (e.g., asthma, diabetes, cardiac problems)	05
6.	Hard of hearing (does not include problems correctable with a hearing aid)	06
7.	Deaf	07
8.	Visually handicapped (does not include problems correctable with glasses)	08
9.	Blind	09
10.	Speech or language impaired (diagnosed)	10
11.	Hyperactivity/attention deficit disorder	11
12.	Learning disabled	12
13.	Low birthweight	13
14.	Positive drug or alcohol toxicology	14
15.	Premature	15
16.	Failure to thrive	16
17.	HIV infected	17
18.	Seriously emotionally disturbed	18

8. What is the one type of handicap above that you would consider the most serious problem? (WRITE THE NUMBER OF THE ONE HANDICAP.)

____

IF YOU CIRCLED ITEM 18. FOR Q7, PLEASE ANSWER Q9. OTHERWISE, SKIP TO Q10.

9. (ASK RESPONDENT TO REFER TO LIST 2.) Did the child have any of the following symptoms? (CIRCLE ALL THAT APPLY.)

1.	Suicide attempts	01
2.	Self-mutilation	02
3.	Eating disorders (e.g., anorexia, bulemia, pica)	03
4.	Bizarre behavior (e.g., talking to inanimate objects, growling)	04
5.	Bizarre language (e.g., persistent repeating of words, refusal to speak)	05
6.	Withdrawal, passivity	06
7.	Psychotic thought disorders	07
8.	Non-psychotic thought disorders	08
9.	Depression	09
10.	Lability and emotional instability (e.g., sharp mood swings)	10
11.	Phobias	11
12.	Sleep disturbance (e.g., sleepwalking, insomnia)	12
13.	Bedwetting/soiling	13
14.	Disorders in peer relations	14
15.	Disorders in relations with authority figures	15
16.	Other (specify) __________	16

10. (ASK RESPONDENT TO REFER TO LIST 3.) What are the source(s) of information about the child's condition? (CIRCLE ALL THAT APPLY.)

01. Police/sheriff	01
02. Probation/corrections	02
03. Coroner/medical examiner	03
04. Social service agency	04
05. School	05
06. Day care	06
07. Hospital/clinic/physician	07
08. Mental health/alcohol or drug abuse treatment program	08
09. Child on whom completing form	09
10. Your observations	10
11. Family member	11
12. Friend/neighbor/other individual	12
13. Anonymous	13
14. Other (specify)	14

11. What is the one source of information that you relied on the most? (WRITE THE NUMBER OF THE ONE SOURCE OF INFORMATION ABOVE.) ______

(IF Q11 = 9 OR 10, SKIP TO Q17.)

12. Does the one source that you just identified have the professional knowledge to diagnose the condition?

Yes	1
No	2
Don't know	8

13. Did the source have the opportunity to examine, assess, or test the child's condition?

Yes	1
No	2
Don't know	8

14. Does the source have knowledge of previous diagnoses or tests?

Yes	1
No	2
Don't know	8

15. Had the source had sufficient contact with the subject to be aware of his/her physical, mental and emotional condition?

Yes	1
No	2
Don't know	8

16. Is there any reason to suspect the source has any bias or negative feelings about the child or family?

Yes	1
No	2
Don't know	8

17. Overall, how reliable is the information on the handicapping condition from this source?

Very reliable	1
Somewhat reliable	2
Somewhat unreliable	3
Very unreliable	4

GO TO BOX 1

ADULT UPDATE

Adult # ____________

The adults in this case are as follows:

1. First/next is ____________ .... Y N → [____________]

who is Male/Female .... Y N → [Male/Female]

and who is: .... Y N →

01. Biological mother .... [01]
02. Adoptive mother .... [02]
03. Stepmother .... [03]
04. Foster mother .... [04]
05. Biological father .... [05]
06. Adoptive father .... [06]
07. Stepfather .... [07]
08. Foster father .... [08]
09. Grandparent .... [09]
10. Aunt/uncle .... [10]
11. Sibling .... [11]
12. Other relative ....
(Specify:) ____________ [12]
13. Parent's girl/boy friend .... [13]
14. Other adult .... [14]
98. Don't know .... [98]

Is that correct? (CIRCLE YES OR NO FOR EACH ITEM. IF NO, ENTER CORRECT ANSWER IN BRACKETED FIELD. REPEAT NEW INFORMATION ALOUD.)

2. His/her alleged role in the maltreatment of the subject child

is:

1. Maltreated child .... [1] (Row 3)
2. Permitted the maltreatment .... [2] (Row 4)
3. Was not involved in maltreatment .... [3]
8. Don't know .... [8]

and s/he is:

1. Primary caretaker .... [1] (Row 5)
2. Other caretaker .... [2] (Row 6)
3. Not a caretaker .... [3]
8. Don't know caretaker status .... [8]

Is that correct? (IF YES, COPY RESPONSE MARKED. IF NO, ENTER/CIRCLE CORRECT INFORMATION IN BRACKETED FIELD TO THE RIGHT. REPEAT NEW INFORMATION ALOUD.)

[CHECK MARKS ON 3A/3B - READ MARKED QUESTION ONLY]

3A.___ The preliminary report indicates that prior to maltreatment, s/he DID have a known or suspected alcohol or drug abuse problem. Is that correct? ____________

[1. (Q4)] (Row 7)
did have
[2. (Q6)]
did not have

(IF YES did have substance abuse problems, CIRCLE 1.
IF NO did not have substance abuse problems, CIRCLE 2.
IN BRACKETED FIELD, REPEAT NEW INFORMATION ALOUD.)

3B.___ The preliminary report indicates that prior to maltreatment, s/he DID NOT have a known or suspected alcohol or drug abuse problem. Is that correct? ____________

[1. (Q7)] (Row 7)
did have
[2. (BOX 2)]
did not have

(IF YES did not have substance abuse problem, CIRCLE 2
IF NO did have substance abuse problem, CIRCLE 1.
IN BRACKETED FIELD, REPEAT NEW INFORMATION ALOUD.)

4. (REFER RESPONDENT TO LIST 4) The type(s) of substance abuse suspected is:

Y N ↓

01	Alcohol (beer, wine, liquor)	[01]
02	Crack	[02]
03	Cocaine	[03]
04	Heroin	[04]
05	Marijuana	[05]
06	Sedatives (barbituates, sleeping pills, Seconal, "downers")	[06]
07	Tranquilizers	[07]
08	Analgesics (pain killers like Darvon, Demarol, Percodan, Tylenol with Codeine)	[08]
09	Stimulants (amphetamines, Preludin, "uppers", speed)	[09]
10	Inhalants (glue, amyl nitrite, "poppers", aerosol sprays)	[10]
11	Hallucinogens (LSD, peyote, mescaline)	[11]
12	PCP (angel dust)	[12]
13	Illegally obtained methadone	[13]
14	Abuses some type of drug - not sure what type	[14]
15	Other drug (Specify): ______________	[__________]

Is that correct? (CIRCLE YES OR NO AT TOP. IF NO, ALSO CIRCLE NEW INFORMATION IN BRACKETED FIELDS. REPEAT NEW INFORMATION ALOUD.)

Is there more than one answer to Q4?

Yes ______________ (Q5)
No ______________ (BOX 2)

5. The primary substance (alcohol or drug) abused was reported to be __________. [__________]
(WRITE CODE NUMBER FROM ABOVE)

GO TO BOX 2

6. What is the reason that you no longer suspect that ______________ (ADULT'S NAME) had an alcohol or drug abuse problem prior to the maltreatment?

____

____

GO TO BOX 2

7. (ASK RESPONDENT TO REFER TO LIST 4.) What type of substance (alcohol or drug) is suspected? (CIRCLE ALL THAT APPLY.)

Alcohol (beer, wine, liquor)	01
Crack	02
Cocaine	03
Heroin	04
Marijuana	05
Sedatives (barbiturates, sleeping pills, Seconal, "downers")	06
Tranquilizers (valium, librium, ativan, etc.)	07
Analgesics (pain killers like Darvon, Demarol, Percodan, Tylenol with Codeine)	08
Stimulants (amphetamines, Preludin, "uppers", speed)	09
Inhalants (glue, amyl nitrite, "poppers", aerosol sprays)	10
Hallucinogens (LSD, peyote, mescaline)	11
PCP (angel dust)	12
Illegally obtained methadone	13
Abuses some type of drug -- not sure what type	14
Other drug (specify)	15

8. What is the one primary substance (alcohol or drug) that is suspected (i.e., the only one which causes the most harm or is used most frequently)? (WRITE THE NUMBER OF THE ONE SUBSTANCE.) ______

9. (ASK RESPONDENT TO REFER TO LIST 3.) What are the source(s) of information about the adult's alcohol or drug abuse? (CIRCLE ALL THAT APPLY.)

Police/sheriff	01
Probation/corrections	02
Coroner/medical examiner	03
Social service agency	04
School	05
Day care	06
Hospital/clinic/physician	07
Mental health/alcohol or drug abuse treatment program	08
Adult on whom completing form	09
Your observations	10
Family member	11
Friend/neighbor/other individual	12
Anonymous	13
Other (specify)	14

10. What is the one source of information that you relied on the most? (WRITE THE NUMBER OF THE ONE SOURCE OF INFORMATION ABOVE.) ______

(IF Q10 = 9 OR 10, PLEASE SKIP TO Q15.)

11. Does the one source that you just identified base his/her belief on a medical or psychological assessment?

Yes	1
No	2
Don't know	8

12. Is it based on knowledge that the person has admitted alcohol or drug abuse, or has received treatment for an alcohol or drug abuse problem?

Yes	1
No	2
Don't know	8

13. Does the source have sufficient contact with the person to be aware of his/her use of alcohol or drugs?

Yes	1
No	2
Don't know	8

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14. Does the source have any reason to be biased against the person (e.g., involved in custody dispute)?

Yes	1
No	2
Don't know	8

15. Overall, how reliable is the information on the person's alcohol or drug abuse from this source?

Very reliable	1
Somewhat reliable	2
Somewhat unreliable	3
Very unreliable	4

GO TO BOX 2

ADDITIONAL ADULT UPDATES

16. Are there any additional adults who are now believed to have been involved in the maltreatment or who had a caretaker role?

Yes	1	(CONTINUE)
No	2	(BOX 3)

17. What is the adult's first name? (RECORD ANSWER ON CASE SUMMARY PAGE ON NEXT AVAILABLE LINE.)

18. What is (NAME)'s relationship to the child who is the subject of this report? (REFER RESPONDENT TO LIST 5.)

01.	Biological mother	01
02.	Adoptive mother	02
03.	Stepmother	03
04.	Foster mother	04
05.	Biological father	05
06.	Adoptive father	06
07.	Stepfather	07
08.	Foster father	08
09.	Grandparent	09
10.	Aunt/uncle	10
11.	Sibling	11
12.	Other relative (Specify:) ______	12
13.	Parent's girl/boy friend	13
14.	Other adult	14
98.	Don't know	98

19. What is (NAME)'s caretaker status?

Primary caretaker	1	(Row 5)
Other caretaker	2	(Row 6)
Not a caretaker	3	
Don't know	8	

20. What is (NAME)'s alleged role in the maltreatment?

Maltreated the child	1	(Row 3)
Permitted maltreatment	2	(Row 4)
Not involved	3	

21. What is (NAME)'s age in years?

______ years old

22. What is (NAME)'s sex?

Male	1
Female	2

23. What is (NAME)'s ethnic group?

American Indian/Alaska Native	1
Asian	2
Black, not Hispanic	3
Hispanic	4
White, not Hispanic	5
Other (specify) ______	6
Don't know	8

24. Prior to the maltreatment, did (NAME) have a known or suspected alcohol or drug abuse problem?

Yes	1	(Row 7)
No	2	(BOX 3)

25. What type of substance (alcohol or drug) is suspected? (CIRCLE ALL THAT APPLY. ASK RESPONDENT TO REFER TO LIST 4.)

Alcohol (beer, wine, liquor)	01
Crack	02
Cocaine	03
Heroin	04
Marijuana	05
Sedatives (barbiturates, sleeping pills, Seconal, "downers")	06
Tranquilizers (valium, librium, ativan, etc.)	07
Analgesics (pain killers like Darvon, Demarol, Percodan, Tylenol with Codeine)	08
Stimulants (amphetamines, Preludin, "uppers", speed)	09
Inhalants (glue, amyl nitrite, "poppers", aerosol sprays)	10
Hallucinogens (LSD, peyote, mescaline)	11
PCP (angel dust)	12
Illegally obtained methadone	13
Abuses some type of drug – not sure what type	14
Other drug (specify) ______	15

26. What is the one primary substance (alcohol or drug) that is suspected (i.e., the only one which causes the most harm or is used most frequently)? (WRITE THE NUMBER OF THE ONE SUBSTANCE.) ______

27. What are the source(s) of information about the adult's alcohol or drug abuse? (CIRCLE ALL THAT APPLY. ASK RESPONDENT TO REFER TO LIST 3.)

Police/sheriff	01
Probation/corrections	02
Coroner/medical examiner	03
Social service agency	04
School	05
Day care	06
Hospital/clinic/physician	07
Mental health/alcohol or drug abuse treatment program	08
Adult on whom completing form	09
Your observations	10
Family member	11
Friend/neighbor/other individual	12
Anonymous	13
Other (specify) ______	14

28. What is the one source of information that you relied on the most? (WRITE THE NUMBER OF THE ONE SOURCE OF INFORMATION ABOVE.) ______

(IF Q10 = 9 OR 10, PLEASE SKIP TO Q33.)

29. Does the one source that you just identified base his/her belief on a medical or psychological assessment?

Yes	1
No	2
Don't know	8

30. Is it based on knowledge that the person has admitted alcohol or drug abuse, or has received treatment for a alcohol or drug abuse problem?

Yes	1
No	2
Don't know	8

31. Does the source have sufficient contact with the person to be aware of their use of alcohol or drugs?

Yes	1
No	2
Don't know	8

32. Does the source have any reason to be biased against the person (e.g., involved in custody dispute)?

Yes	1
No	2
Don't know	8

33. Overall, how reliable is the information on the person's alcohol or drug abuse from this source?

Very reliable	1
Somewhat reliable	2
Somewhat unreliable	3
Very unreliable	4

GO TO BOX 3

PART 2: FAMILY HISTORY AND CHARACTERISTICS

Now, I'd like to turn to another topic – family history and characteristics.

1. At the time of maltreatment, what was the marital status of the primary caretaker?

Never married	1
Divorced	2
Separated	3
Widowed	4
Married	5
Don't know	8

2. What is the highest grade of school completed for the primary caretaker?

Less than high school	1
High school graduate or GED (General Equivalency Diploma) completion	2
Some college	3
College graduate	4
Don't know	8

3. (ASK RESPONDENT TO REFER TO LIST 6.) In what range is the total annual household income?

Less than $10,000	1
10,000-14,999	2
15,000-19,999	3
20,000-24,999	4
25,000-29,999	5
30,000-34,999	6
35,000 or more	7
Don't know	8

4. (ASK RESPONDENT TO REFER TO LIST 7.) What was the primary source of income at the time of maltreatment? (ACCEPT ONLY ONE RESPONSE.)

Employment	1
AFDC (Aid to Families with Dependent Children)	2
Other welfare (e.g., General Assistance)	3
SSI (Supplemental Security Income)	4
Social Security or other retirement program	5
Disability	6
Other (specify)__________	7
Don't know	8

5. Was this family seen by the child welfare agency prior to this maltreatment?

Yes	1
No	2 (Q7)
Don't know	8 (Q7)

6. In what year was the family first seen by the agency? (WRITE LAST 2 DIGITS OF YEAR ON LINE BELOW. CIRCLE 98 IF DK.)

1 9 __ __

Don't know	98

7. Have there been previous maltreatment allegations in which any member of the family was the perpetrator?

Yes	1
No	2 (Q10)
Don't know	8 (Q10)

8. Were any of the prior allegations substantiated?

Yes........ 1
No........ 2
Don't know........ 8

9a. Were any of the children now in the household the subject of a previous allegation?

Yes........ 1
No........ 2 (Q9c)
Don't know........ 8 (Q9c)

9b. Which children were the subjects of a previous allegation?

Name

9c. Was any child who is not currently part of the household, the subject of a previous allegation?

Yes........ 1 (Q9d)
No........ 2 (BOX 4)
Don't know........ 8 (BOX 4)

BOX 4
CHECK Q9A

Q9A YES........ 1 (Continue)
NO........ 2 (Q10)
DON'T KNOW........ 8 (Q10)

9d. Were any of the children who were the subject of a previous allegation placed in foster care?

Yes........ 1
No........ 2 (Q10)
Don't Know........ 8 (Q10)

9e. Which children who were the subject of a previous allegation were placed in foster care? (ENTER NAMES OF THE CHILDREN.)

Name

10. Was the family seen by the agency for any reason other than a maltreatment allegation?

Yes........ 1
No........ 2 (Q12)
Don't know........ 8 (Q12)

11. Please describe the reason:

12. (ASK RESPONDENT TO REFER TO LIST 8.) To the best of your knowledge, was the family receiving any of the following services at the time of the maltreatment? (CIRCLE ALL THAT APPLY.)

a.	None	01
b.	Behavior management training	02
c.	Counseling, family or other group	03
d.	Counseling, individual	04
e.	Day care	05
f.	Educational services	06
g.	Employment/training	07
h.	Habilitation or rehabilitation	08
i.	Homemaker service	09
j.	Household management	10
k.	Housing assistance	11
l.	Legal services	12
m.	Medical services	13
n.	Mental health care	14
o.	Parent training	15
p.	Respite care	16
q.	Drug or alcohol abuse treatment	17
r.	Transportation	18
s.	Other (specify)________________	19

13a. (ASK RESPONDENT TO REFER TO LIST 9.) At the time of the maltreatment, was there any evidence to suggest that the primary caretaker (NAME) had any of the following problems? (CIRCLE ALL THAT APPLY.)

		13a. Primary Caretaker Name __________	13b. Other Caretaker Name __________
a.	Mental health problems	1	1
b.	Marital discord/spouse abuse	2	2
c.	Physical illness or handicap	3	3
d.	Mental retardation/developmental disability	4	4
e.	Arrest/incarceration	5	5
f.	Lack of housing	6	6
g.	Serious/chronic financial problems	7	7
h.	Other (specify)________________	8	8
i.	None	9	9

BOX 5. CHECK CASE SUMMARY. ARE THERE ANY OTHER CARETAKERS CHECKED?

YES _____ ASK Q13b USING 1ST PERSON LISTED ONLY
NO _____ GO TO PART 3A

13b. (REFER TO LIST 9.) How about ____________ (NAME FROM OTHER CARETAKER LIST)? At the time of the maltreatment, was there any evidence to suggest that s/he had any of the following problems? (RECORD RESPONSE IN COL. 13b ABOVE. CIRCLE ALL THAT APPLY.)

PART 3A: CHILD'S HISTORY AND CHARACTERISTICS

COMPLETE QUESTIONS 1 AND 2 FOR EACH CHILD (ROW 1 CASE SUMMARY FORM), WHOSE MALTREATMENT WAS SUBSTANTIATED.

Now, I'd like to get some additional information on each child whose maltreatment was substantiated. In this case, that would be (READ NAMES FROM CASE SUMMARY ROW 1). Let's start with (CHILD'S NAME).

	Child's Name ____________	Child's Name ____________	Child's Name ____________
1. (ASK RESPONDENT TO REFER TO LIST 10.) To the best of your knowledge, was (NAME) receiving any of the following services, from public or private agencies, at the time of the maltreatment? (CIRCLE ALL THAT APPLY.)			
a. Behavior modification	1	1	1
b. Counseling	2	2	2
c. Crisis care	3	3	3
d. Day treatment	4	4	4
e. Employment/training	5	5	5
f. Habilitation or rehabilitation	6	6	6
g. Head Start	7	7	7
h. Independent living services	8	8	8
i. Infant stimulation program	9	9	9
j. Legal services	10	10	10
k. Medical services	11	11	11
l. Mental health care	12	12	12
m. Occupational therapy	13	13	13
n. Physical therapy	14	14	14
o. Psychological evaluation	15	15	15
p. Remedial education	16	16	16
q. Sheltered employment	17	17	17
r. Speech therapy	18	18	18
s. Alcohol or drug abuse treatment	19	19	19
t. Vocational education	20	20	20
u. Other (specify)	______ 21	______ 21	______ 21
v. Don't know	98	98	98
w. None	99	99	99
2. (REFER TO LIST 11.) At the time of the maltreatment, was there any evidence to suggest that (NAME) had any of the following problems? (CIRCLE ALL THAT APPLY.)			
a. School behavior problem	1	1	1
b. Truancy or attendance problem	2	2	2
c. Substance abuse	3	3	3
d. Running away	4	4	4
e. Delinquency	5	5	5
f. Performing below age-appropriate grade level	6	6	6
g. Other behavior problems (specify)_	______ 7	______ 7	______ 7
h. Don't know	8	8	8
i. None	9	9	9

BOX 6. CHECK CASE SUMMARY. ARE THERE ANY ADDITIONAL CHILDREN WHOSE MALTREATMENT WAS SUBSTANTIATED?

YES.......... PART 3A, Q1, NEXT CHILD
NO........... PART 3B

PART 3B: THE NATURE OF THE MALTREATMENT

ASK PART 3B FOR SAME CHILDREN AS PART 3A (ROW 1 ON CASE SUMMARY).

Now, I'd like to get some additional information on the nature of each child's maltreatment.

First/Next is (NAME).	Child's Name __________	Child's Name __________	Child's Name __________
1. Was there any injury, even minor, or impairment to (NAME) as a result of the maltreatment?			
Yes	1	1	1
No	2 (BOX 7)	2 (BOX 7)	2 (BOX 7)
Uncertain	3 (BOX 7)	3 (BOX 7)	3 (BOX 7)
2. Was the injury or impairment:			
Fatal	1 (BOX 7)	1 (BOX 7)	1 (BOX 7)
Serious	2	2	2
Moderate	3	3	3
Minor	4	4	4
Too soon to tell	5	5	5
Don't Know	8	8	8
3. Has the injury or impairment resulted in any permanent or long-term handicapping condition?			
Definitely Yes	1	1	1
Likely	2	2	2
Unlikely	3	3	3
Definitely Not	4	4	4
Don't Know	8	8	8

4. Please describe the nature of the injury or impairment for (NAME):

Child's Name	Description
__________	______________________________ ______________________________
__________	______________________________ ______________________________
__________	______________________________ ______________________________

BOX 7. CHECK CASE SUMMARY. Are there any other children whose maltreatment was substantiated?

YES........ (PART 3B, Q1 for next child)
NO.......... (PART 3C)

PART 3C: CHILD-RELATED ACTIVITIES

ASK PART 3C FOR SAME CHILDREN AS PART 3B (ROW 1 ON CASE SUMMARY).

I'd now like to turn to another topic – the investigation. For each child whose maltreatment was substantiated, I have some questions about how the investigation was conducted. Let's begin with (NAME).

	Child's Name ________	Child's Name ________	Child's Name ________
1a. (ASK RESPONDENT TO REFER TO LIST 12.) For each of the following people/agencies, please indicate if a CPS worker was able to contact them during or since the investigation concerning (NAME).			
	Yes No DK	Yes No DK	Yes No DK
1. Teacher or other school personnel			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
2. Physician or other medical personnel			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
3. Mental health personnel			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
4. Social service program personnel			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
5. Law enforcement personnel			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
6. Neighbors/landlord			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
7. Friends			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
8.* Parent/caretaker			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
9.* Other adult family members (not perpetrator or parent/caretaker)			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
10.* Perpetrator			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
11.* Child (victim)			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
12.* Other child			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8
13. Other (specify)			
(a) Contacted	__ 1 2 8	__ 1 2 8	__ 1 2 8
(b) Child Health Discussed	__ 1 2 8	__ 1 2 8	__ 1 2 8

(IF ITEMS 8-12 ABOVE ARE NOT VOLUNTEERED, ASK ABOUT EACH ONE SPECIFICALLY.)

1b. (FOR EACH ITEM ANSWERED "YES" TO Q.1a) Was the child's overall physical or mental health discussed?

	Child's Name __________	Child's Name __________	Child's Name __________
2. Were any of the following records/documents concerning (NAME) examined during or since the investigation? (CIRCLE ALL THAT APPLY.)			
None	1	1	1
School records	2	2	2
Medical records	3	3	3
Psychological assessments; developmental/intellectual functioning tests	4	4	4
Police/probation reports	5	5	5
Other (specify)	__________ 6 __________	__________ 6 __________	__________ 6 __________
3. Was (NAME) screened for any of the following problems during or since the investigation?	Yes No DK	Yes No DK	Yes No DK
Vision problems	1 2 8	1 2 8	1 2 8
Hearing loss	1 2 8	1 2 8	1 2 8
Physical coordination and development	1 2 8	1 2 8	1 2 8
Intellectual functioning	1 2 8	1 2 8	1 2 8
Social/emotional health	1 2 8	1 2 8	1 2 8
4. Was (NAME) examined by a physician during or since the investigation?	Yes No DK 1 2 8	Yes No DK 1 2 8	Yes No DK 1 2 8
5. Was an assessment made of (NAME)'s intelligence or developmental functioning during or since the investigation?	Yes No DK 1 2 8	Yes No DK 1 2 8	Yes No DK 1 2 8

CHECK CASE SUMMARY.
Are there any other children whose maltreatment was substantiated (Row 1)?
Yes - GO TO PART 3C-Q1, NEXT CHILD
No - GO TO PART 4A.

PART 4A: CASE ACTIVITIES

I'd like to ask you some questions about other aspects of the investigation.

1. First have you been the primary worker for this case since it began?

Yes	1	(Q3)
No	2	

2. How many previous workers were assigned to the case? ______

3a. (ASK RESPONDENT TO REFER TO LIST 12.) For each of the following people/agencies, please indicate if they were contacted during or since the investigation.

		(a) Contacted			(b) Substance Abuse		
		Yes	No	DK	Yes	No	DK
1.	Teacher or other school personnel	1	2	8	1	2	8
2.	Physician or other medical personnel	1	2	8	1	2	8
3.	Mental health personnel	1	2	8	1	2	8
4.	Social service program personnel	1	2	8	1	2	8
5.	Law enforcement personnel	1	2	8	1	2	8
6.	Neighbors/landlord	1	2	8	1	2	8
7.	Friends	1	2	8	1	2	8
8.*	Parent/caretaker	1	2	8	1	2	8
9.*	Other adult family members (not perpetrator or parent)	1	2	8	1	2	8
10.*	Perpetrator	1	2	8	1	2	8
11.*	Child (victim)	1	2	8	1	2	8
12.*	Other child	1	2	8	1	2	8
13.	Other (specify)__________	1	2	8	1	2	8

(IF ITEMS 8-12 ABOVE ARE NOT VOLUNTEERED, ASK ABOUT EACH ONE SPECIFICALLY.)

3b. (FOR EACH ITEM ANSWERED "YES" TO Q.3a) Was possibility of alcohol or drug abuse by any family member discussed? By family, we mean all adults in the case including caretakers, perpetrators and adults who permittad the maltreatment.

BOX 8. CHECK CASE SUMMARY ROW 3. ASK Q4-5 FOR EACH ADULT IDENTIFIED AS PERPETRATOR. WRITE NAME ON LINE BELOW. IF NO PERPETRATOR, GO TO Q6.

The next two questions refer to the perpetrators of the maltreatment.

4. Was (NAME OF PERPETRATOR) assessed by a medical or mental health professional for any alcohol or drug abuse problem during or since the investigation?

Adult's Name ________			Adult's Name ________			Adult's Name ________		
Yes	No	DK	Yes	No	DK	Yes	No	DK
1	2	8	1	2	8	1	2	8

5. Did (NAME OF PERPETRATOR) acknowledge or deny the allegation of maltreatment?

Adult's Name ________			Adult's Name ________			Adult's Name ________		
Yes	No	DK	Yes	No	DK	Yes	No	DK
1	2	8	1	2	8	1	2	8

6. Was the primary caretaker, (NAME), assessed by a medical or mental health professional for any alcohol or drug abuse problem during or since the investigation?

Yes	1
No	2
Don't Know	8

7. To what extent did the primary caretaker cooperate with the investigation?

Very cooperative	1
Somewhat cooperative	2
Neither cooperative nor uncooperative	3
Somewhat uncooperative	4
Very uncooperative	5
Don't know	8

8. Since the case was substantiated, how many times did you or another caseworker visit the family?

___ ___ = Number of visits ("00" = NO VISITS)

9a. Were there any problems with the family which prevented or limited home visits?

Yes	1	
No	2	(Q10)
Don't know	8	(Q10)

9b. Please describe:

____

____

____

10. As a result of the maltreatment, were any services offered to any adult who we have listed for this case?

Yes	1	
No	2	(Q12)

11. (ASK RESPONDENT TO REFER TO LIST 13.) As a result of the maltreatment, which of the following services were (a) offered to the family, but not provided; (b) referred, uncertain if services were provided; or (c) provided by CPS agency or another agency.

		(a) Offered	(b) Referred	(c) Provided	(d) Don't Know
1.	Behavior management	1	2	3	8
2.	Day care	1	2	3	8
3.	Educational services	1	2	3	8
4.	Employment/training	1	2	3	8
5.	Habilitation or rehabilitation	1	2	3	8
6.	Homemaker service	1	2	3	8
7.	Household management	1	2	3	8
8.	Housing assistance	1	2	3	8
9.	Individual counseling	1	2	3	8
10.	Family counseling	1	2	3	8
11.	Other mental health services (specify) ______	1	2	3	8
12.	Legal services	1	2	3	8
13.	Medical services	1	2	3	8
14.	Parent training	1	2	3	8
15.	Peer support group	1	2	3	8
16.	Respite care	1	2	3	8
17.	Transportation	1	2	3	8
18.	Other (specify) ______	1	2	3	8

IF THERE ARE NO ITEMS CIRCLED IN BOX, SKIP TO Q13.

12. (ASK RESPONDENT TO REFER TO LIST 14.) What were the reasons that some services were offered but not provided? (CIRCLE ALL THAT APPLY.)

a.	Client did not want services	1
b.	Appropriate services did not exist	2
c.	Waiting list for service was too long	3
d.	Transportation problems prevented client access	4
e.	Day care problems prevented client access	5
f.	Cost of service was prohibitive	6
g.	Other (specify)__________	7
h.	Don't know	8

13. Since the date of report for this maltreatment, have there been any new allegations of maltreatment of children in the household?

Yes	1
No	2
Don't know	8

14. (ASK RESPONDENT TO REFER TO LIST 15.) What is the current status of the case?

Case closed/no other action	1
Case open/protective services only	2
Case open/protective services and preventive services	3
Case open/foster care	4
Case transferred from protective to preventive services	5
Action pending	6
Other (specify)__________	7
Don't know	8

PART 4B: FOSTER CARE PLACEMENT AND SERVICES TO CHILDREN

1a. As a result of the maltreatment, were any children in the household placed in foster care?

Yes.. 1
No.. 2 (Q5A)

1b. Which children were placed in foster care?
(WRITE NAMES ON LINES BELOW)

	Child's Name ________	Child's Name ________	Child's Name ________
2a. In what type of setting was he/she placed?			
Foster family home	____ 1	____ 1	____ 1
Relative home	____ 2	____ 2	____ 2
Group home	____ 3	____ 3	____ 3
Institution	____ 4	____ 4	____ 4
Other (specify)	____ 5 ________	____ 5 ________	____ 5 ________
2b. Is child still in foster care?			
Yes	____ 1	____ 1	____ 1
No	____ 2 (Q4)	____ 2 (Q4)	____ 2 (Q4)
Don't know	____ 8 (Q5A)	____ 8 (Q5A)	____ 8 (Q5A)
3. What is the case plan goal for that child?			
Return home	____ 1 (Q5A)	____ 1 (Q5A)	____ 1 (Q5A)
Placement with other relative	____ 2 (Q5A)	____ 2 (Q5A)	____ 2 (Q5A)
Adoption	____ 3 (Q5A)	____ 3 (Q5A)	____ 3 (Q5A)
Permanent/long-term foster care	____ 4 (Q5A)	____ 4 (Q5A)	____ 4 (Q5A)
Emancipation	____ 5 (Q5A)	____ 5 (Q5A)	____ 5 (Q5A)
Other (specify)	____ 6 (Q5A) ________	____ 6 (Q5A) ________	____ 6 (Q5A) ________
4. What was the outcome of foster care for the child?			
Return home	____ 1	____ 1	____ 1
Placement with other relative	____ 2	____ 2	____ 2
Adoption	____ 3	____ 3	____ 3
Permanent/long-term foster care	____ 4	____ 4	____ 4
Emancipation	____ 5	____ 5	____ 5
Other (specify)	____ 6 ________	____ 6 ________	____ 6 ________

5a. As a result of the maltreatment, were any services provided to any child whose maltreatment was substantiated?

Yes.. 1
No... 2 (BOX 9)

5b. Which children received these services?

ENTER EACH CHILD'S NAME ON LINES BELOW IN CHART. THEN ASK QUESTION 6 FOR EACH CHILD.

6. (ASK RESPONDENT TO REFER TO LIST 16.) Please indicate which of the following services were (a) offered to the child, but not provided (b) referred, uncertain if service was provided, or (c) provided by CPS agency or another agency.

	Child's Name ______				Child's Name ______				Child's Name ______			
	Off	Ref	Prv	DK	Off	Ref	Prv	DK	Off	Ref	Prv	DK
01. Behavior modification	1	2	3	8	1	2	3	8	1	2	3	8
02. Counseling	1	2	3	8	1	2	3	8	1	2	3	8
03. Crisis Care	1	2	3	8	1	2	3	8	1	2	3	8
04. Day treatment	1	2	3	8	1	2	3	8	1	2	3	8
05. Employment/training	1	2	3	8	1	2	3	8	1	2	3	8
06. Habilitation or rehabilitation	1	2	3	8	1	2	3	8	1	2	3	8
07. Head Start	1	2	3	8	1	2	3	8	1	2	3	8
08. Infant stimulation programs	1	2	3	8	1	2	3	8	1	2	3	8
09. Independent living services	1	2	3	8	1	2	3	8	1	2	3	8
10. Legal services	1	2	3	8	1	2	3	8	1	2	3	8
11. Medical services	1	2	3	8	1	2	3	8	1	2	3	8
12. Mental health care	1	2	3	8	1	2	3	8	1	2	3	8
13. Parent training	1	2	3	8	1	2	3	8	1	2	3	8
14. Occupational therapy	1	2	3	8	1	2	3	8	1	2	3	8
15. Physical therapy	1	2	3	8	1	2	3	8	1	2	3	8
16. Psychological evaluation	1	2	3	8	1	2	3	8	1	2	3	8
17. Remedial education	1	2	3	8	1	2	3	8	1	2	3	8
18. Sheltered employment	1	2	3	8	1	2	3	8	1	2	3	8
19. Speech therapy	1	2	3	8	1	2	3	8	1	2	3	8
20. Alcohol or drug abuse treatment	1	2	3	8	1	2	3	8	1	2	3	8
21. Vocational education	1	2	3	8	1	2	3	8	1	2	3	8
22. Other (specify) ______	1	2	3	8	1	2	3	8	1	2	3	8

BOX 9. CHECK CASE SUMMARY. Are there any children whose maltreatment was substantiated who also had a handicapping condition? (ROW 1 AND ROW 2)

YES ______ GO TO PART 5A.
NO ______ Are there any adults with substance abuse (ROW 7) who also have check in shaded area?

YES ______ GO TO PART 6A.
NO ______ (END OF INTERVIEW) That concludes this interview. Thank you again for your help. We greatly appreciate it.

PART 5A: SERVICES FOR SUBSTANTIATED VICTIMS WITH KNOWN OR SUSPECTED HANDICAPS

ASK PART 5A FOR EACH CHILD WITH "X" IN BOTH ROW 1 AND ROW 2 ON CASE SUMMARY.

Now, I'd like to get some additional information on the services for the children with handicaps whose maltreatment is substantiated.

	Child's Name ____	Child's Name ____	Child's Name ____
1a. Is (NAME) receiving services specifically related to his/her handicapping condition?			
Yes	___ 1	___ 1	___ 1
No	___ 2 (Q2)	___ 2 (Q2)	___ 2 (Q2)

1b. Which of the services that you just told me (NAME) is receiving are specifically related to his/her handicapping condition?

REFER TO Q6 OF PART 4B (PAGE 4-5), LIST THE NUMBER OF EACH SERVICE PROVIDED BELOW, AND ASK WHETHER OR NOT EACH SERVICE PROVIDED IS RELATED TO CHILD'S HANDICAPPING CONDITION.

Child's Name ____		Child's Name ____		Child's Name ____	
Number of service provided	Service specifically related to condition	Number of service provided	Service specifically related to condition	Number of service provided	Service specifically related to condition
	Y N DK		Y N DK		Y N DK
____	1 2 8	____	1 2 8	____	1 2 8
____	1 2 8	____	1 2 8	____	1 2 8
____	1 2 8	____	1 2 8	____	1 2 8
____	1 2 8	____	1 2 8	____	1 2 8
____	1 2 8	____	1 2 8	____	1 2 8
____	1 2 8	____	1 2 8	____	1 2 8

	Child's Name ____	Child's Name ____	Child's Name ____
1c. Who provides these services? (CIRCLE ALL THAT APPLY.)			
a. You, the worker	___ 1	___ 1	___ 1
b. Other worker in child welfare agency	___ 2	___ 2	___ 2
c. Other public agency	___ 3	___ 3	___ 3
d. Private agency or individual	___ 4	___ 4	___ 4
e. Other (specify)____	___ 5	___ 5	___ 5
f. Don't know	___ 8	___ 8	___ 8

	Child's Name __________	Child's Name __________	Child's Name __________
2. Did (NAME)'s condition affect the services that could be offered? Yes .... No .... Don't know	______ 1 ______ 2 ______ 8	______ 1 ______ 2 ______ 8	______ 1 ______ 2 ______ 8
3a. Did (NAME)'s condition affect the disposition of case? Yes .... No .... Don't know	______ 1 ______ 2 (Q4) ______ 8 (Q4)	______ 1 ______ 2 (Q4) ______ 8 (Q4)	______ 1 ______ 2 (Q4) ______ 8 (Q4)

3b. In what way?

Child's Name

__________ ____

____

__________ ____

____

__________ ____

____

	Child's Name __________	Child's Name __________	Child's Name __________
4. Does (NAME)'s condition affect the anticipated outcomes of the case? Yes .... No .... Don't know	______ 1 ______ 2 ______ 8	______ 1 ______ 2 ______ 8	______ 1 ______ 2 ______ 8
5. How well do you think (NAME)'s parents/caretakers understand the way that his/her condition limits his/her functioning? Completely understand .... Partially understand .... Don't understand at all .... Caretakers mixed in understanding .... Don't know	______ 1 ______ 2 ______ 3 ______ 4 ______ 8	______ 1 ______ 2 ______ 3 ______ 4 ______ 8	______ 1 ______ 2 ______ 3 ______ 4 ______ 8
6a. Does (NAME)'s condition place any additional burden on the parent/caretaker? Yes .... No .... Don't know	______ 1 ______ 2 (Q7a) ______ 8 (Q7a)	______ 1 ______ 2 (Q7a) ______ 8 (Q7a)	______ 1 ______ 2 (Q7a) ______ 8 (Q7a)

6b. If yes, please describe any additional burden:

Child's Name

________ ____

________ ____

________ ____

________ ____

________ ____

________ ____

	Child's Name ________	Child's Name ________	Child's Name ________
7a. In your opinion, did (NAME)'s condition in any way "cause" or lead to the maltreatment?			
Yes	___ 1	___ 1	___ 1
No	___ 2 (BOX 10)	___ 2 (BOX 10)	___ 2 (BOX 10)
Don't know	___ 8 (BOX 10)	___ 8 (BOX 10)	___ 8 (BOX 10)

7b. Please describe:

Child's Name

________ ____

________ ____

________ ____

________ ____

________ ____

BOX 10. CHECK CASE SUMMARY, ROW 1 AND ROW 2. Are there any more children with handicaps whose maltreatment was substantiated?

Yes ______ (PART 5A - Q1 - NEXT CHILD)
No ______ (PART 5B)

PART 5B: SUBSTANTIATED VICTIMS WITH SUSPECTED HANDICAPPING CONDITIONS

ASK PART 5B FOR SAME CHILDREN AS PART 5A (BOTH ROW 1 AND ROW 2).

Now, I'd like to get some additional information on (NAME)'s handicapping condition.

	Child's Name ______	Child's Name ______	Child's Name ______
1. Has (NAME)'s condition been diagnosed by a professional?			
Yes	1	1	1
No	2 (Q6a)	2 (Q6a)	2 (Q6a)
Don't know	8 (Q6a)	8 (Q6a)	8 (Q6a)
2. (ASK RESPONDENT TO REFER TO LIST 17.) Which of the following has diagnosed (NAME)'s condition? (CIRCLE ALL THAT APPLY.)			
a. Physician	1	1	1
b. Other health personnel	2	2	2
c. Psychiatrist	3	3	3
d. Clinical psychologist	4	4	4
e. Educational psychologist	5	5	5
f. Other mental health professional	6	6	6
g. School teacher, guidance counselor or principal	7	7	7
h. Other school personnel	8	8	8
i. Other (specify)	9	9	9
3. When was the diagnosis made?			
Before maltreatment	1	1	1
During investigation of the maltreatment	2	2	2
After the maltreatment was substantiated	3	3	3
4. Do you have a copy of the medical, school, or other diagnostic report or evaluation?			
Yes	1	1	1
No	2	2	2
5. Have you or any other caseworker spoken or met with the professional who made the diagnosis or other professionals concerning (NAME)'s condition?			
Yes	1	1	1
No	2	2	2
6a. Does (NAME) attend school?			
Yes	1	1	1
No	2 (Q7a)	2 (Q7a)	2 (Q7a)
Don't know	8 (Q7a)	8 (Q7a)	8 (Q7a)
6b. Has (NAME) been in a special school or special class for children with a handicapping condition?			
Yes	1	1	1
No	2	2	2
Don't know	8	8	8

	Child's Name	Child's Name	Child's Name
7a. Does (NAME) routinely take any medication for his/her condition?			
Yes	1	1	1
No	2 (Q8)	2 (Q8)	2 (Q8)
Don't know	8 (Q8)	8 (Q8)	8 (Q8)
7b. What medication? (WRITE RESPONSE IN APPROPRIATE COLUMN. ENTER DK IF RESPONDENT DOESN'T KNOW)			
8. Do you suspect any impairment in (NAME)'s intellectual functioning?			
Yes	1	1	1
No	2 (Q10)	2 (Q10)	2 (Q10)
Don't know	8 (Q10)	8 (Q10)	8 (Q10)
9. (ASK RESPONDENT TO REFER TO LIST 18.) Has (NAME) been classified as:			
Not retarded, but below average intelligence	1	1	1
Mildly retarded	2	2	2
Moderately retarded	3	3	3
Severely retarded	4	4	4
Profoundly retarded	5	5	5
Level of retardation undetermined	6	6	6
Conflicting diagnosis on level of retardation	7	7	7
Don't know	8	8	8
10. (ASK RESPONDENT TO REFER TO LIST 19.) Which of the following describes (NAME)'s condition? (CIRCLE ALL THAT APPLY.)			
1. None	01	01	01
2. Bedridden or wheelchair, unable to propel self	02	02	02
3. In wheelchair, able to propel self	03	03	03
4. Walks with braces or crutches	04	04	04
5. Impaired vision	05	05	05
6. Impaired hearing	06	06	06
7. Communication disorder	07	07	07
8. Speech disorder	08	08	08
9. Missing or malformed limbs	09	09	09
10. Bodily functions require continual monitoring	10	10	10
11. Special medication needed	11	11	11
12. 24-hour supervision needed	12	12	12
13. Other (specify)	13	13	13
98. Don't know	98	98	98

	Child's Name ________	Child's Name ________	Child's Name ________
11. (ASK RESPONDENT TO REFER TO LIST 20.) What substantial limitations to daily living does (NAME) have? (CIRCLE ALL THAT APPLY.)			
a. None	________ 1	________ 1	________ 1
b. Needs help eating	________ 2	________ 2	________ 2
c. Needs help dressing	________ 3	________ 3	________ 3
d. Needs help toileting	________ 4	________ 4	________ 4
e. Needs help in travel	________ 5	________ 5	________ 5
f. Not reliably toilet trained	________ 6	________ 6	________ 6
g. Has problems communicating	________ 7	________ 7	________ 7
h. Don't know	________ 8	________ 8	________ 8

BOX 11. CHECK CASE SUMMARY. Are there any more maltreated children with handicapping conditions?

Yes ________ (PART 5B - next child)
No ________ Do any of the adults suspected of substance abuse (Row 7) also have "X" in shaded area (Rows 3-5)?

Yes ________ GO TO PART 6A
No ________ (END INTERVIEW) That concludes this interview. Thank you again for your help. We greatly appreciate it.

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PART 6A: SERVICES FOR CASES WITH KNOWN OR SUSPECTED ALCOHOL OR DRUG ABUSE

ASK PART 6A FOR EACH ADULT WITH SUBSTANCE ABUSE (ROW 7) WHO ALSO HAS "X" IN SHADED AREA (ROWS 3-5).

Next I'd like to get some additional information on the alcohol or drug abuse treatment services provided to adults with key roles in this case who are suspected of alcohol or drug abuse. (REVIEW WITH CASEWORKER WHO THESE INVIDUALS ARE. Example: "John is suspected of alcohol or drug abuse and he is the primary caretaker. Francine is also suspected of alcohol or drug abuse and she is a perpetrator.")

First/next is (NAME).

	Adult's Name ______	Adult's Name ______	Adult's Name ______
1a. Has (NAME) been evaluated by an individual or facility for an alcohol or drug abuse problem since the maltreatment?			
Yes	______ 1	______ 1	______ 1
No	______ 2 (Q2a)	______ 2 (Q2a)	______ 2 (Q2a)
1b. Who evaluated (NAME)'s condition?			
Physician	______ 1	______ 1	______ 1
Psychiatrist	______ 2	______ 2	______ 2
Licensed psychologist	______ 3	______ 3	______ 3
Substance abuse counselor	______ 4	______ 4	______ 4
Other (specify)	______ 5 ______	______ 5 ______	______ 5 ______
Don't know	______ 8	______ 8	______ 8
2a. Since the maltreatment, has (NAME) received treatment for his/her alcohol or drug abuse problem?			
Yes	______ 1	______ 1	______ 1
No	______ 2 (Q4)	______ 2 (Q4)	______ 2 (Q4)
Don't know	______ 8 (Q4)	______ 8 (Q4)	______ 8 (Q4)
2b. (ASK RESPONDENT TO REFER TO LIST 21.) What type of treatment did (NAME) receive? (CIRCLE ALL THAT APPLY.)			
Drug or alcohol outpatient counseling	______ 1	______ 1	______ 1
Residential treatment	______ 2	______ 2	______ 2
Methadone maintenance	______ 3	______ 3	______ 3
Detoxification	______ 4	______ 4	______ 4
Narcotics or Alcoholics Anonymous	______ 5	______ 5	______ 5
Psychological/mental health counseling	______ 6	______ 6	______ 6
Other (specify)	______ 7 ______	______ 7 ______	______ 7 ______
3. Is (NAME) currently receiving treatment?			
Yes	______ 1 (Q6a)	______ 1 (Q6a)	______ 1 (Q6a)
No	______ 2	______ 2	______ 2
Don't know	______ 8	______ 8	______ 8

	Adult's Name ________	Adult's Name ________	Adult's Name ________
4. Were alcohol or drug abuse treatment services offered to (NAME) but not provided?			
Yes	____ 1	____ 1	____ 1
No	____ 2 (Q6a)	____ 2 (Q6a)	____ 2 (Q6a)
Don't know	____ 8 (Q6a)	____ 8 (Q6a)	____ 8 (Q6a)
5. (ASK RESPONDENT TO REFER TO LIST 22.) What was the primary reason for non-provision?			
Client refused	____ 1	____ 1	____ 1
Prohibitive waiting lists for services	____ 2	____ 2	____ 2
Appropriate services not available	____ 3	____ 3	____ 3
Could not afford services	____ 4	____ 4	____ 4
Transportation problems prohibited access to services	____ 5	____ 5	____ 5
Child care problems prohibited access to services	____ 6	____ 6	____ 6
Other (specify)	____ 7 ________ ________	____ 7 ________ ________	____ 7 ________ ________
Don't Know	____ 8	____ 8	____ 8
6a. Did (NAME)'s alcohol or drug abuse in any way interfere with or affect the provision of other services to the family?			
Yes	____ 1	____ 1	____ 1
No	____ 2 (Q7)	____ 2 (Q7)	____ 2 (Q7)
Don't know	____ 8 (Q7)	____ 8 (Q7)	____ 8 (Q7)

6b. Please describe:

Adult's Name	Description
________	________________________________
________	________________________________
________	________________________________

7. Is there evidence to suggest that (NAME) was under the influence of alcohol or drugs at the time of the maltreatment?			
Yes	____ 1	____ 1	____ 1
No	____ 2	____ 2	____ 2
Don't know	____ 8	____ 8	____ 8
8a. Did (NAME)'s alcohol or drug abuse affect the disposition of the case after it was substantiated?			
Yes	____ 1	____ 1	____ 1
No	____ 2 (Q9a)	____ 2 (Q9a)	____ 2 (Q9a)
Don't know	____ 8 (Q9a)	____ 8 (Q9a)	____ 8 (Q9a)

8b. Please describe:

Adult's Name	Description
____________	____
____________	____
____________	____

	Adult's Name ____________	Adult's Name ____________	Adult's Name ____________
9a. Did (NAME)'s alcohol or drug abuse affect the expected outcomes of the case?			
Yes	______ 1	______ 1	______ 1
No	______ 2 (Q10a)	______ 2 (Q10a)	______ 2 (Q10a)
Don't know	______ 8 (Q10a)	______ 8 (Q10a)	______ 8 (Q10a)

9b. Please describe:

Adult's Name	Description
____________	____
____________	____
____________	____

	Adult's Name ____________	Adult's Name ____________	Adult's Name ____________
10a. In your opinion, did (NAME)'s alcohol or drug abuse "cause" or lead to the maltreatment?			
Yes	______ 1	______ 1	______ 1
No	______ 2 (BOX 12)	______ 2 (BOX 12)	______ 2 (BOX 12)
Don't know	______ 8 (BOX 12)	______ 8 (BOX 12)	______ 8 (BOX 12)

10b. Please describe:

Adult's Name	Description
____________	____
____________	____
____________	____

BOX 12
CHECK CASE SUMMARY.

Are there any additional adults with substance abuse (Row 7) who also have check in shaded area (Rows 3-5)?

PART 6B: ADULTS WITH SUSPECTED ALCOHOL OR DRUG ABUSE

ASK PART 6B FOR SAME ADULTS AS PART 6A (ROW 7 AND ROWS 3-5)

Now, I'd like to get some additional information on (NAME)'s alcohol or drug abuse.

1. Briefly describe the information you received which makes you suspect alcohol or drug abuse.

Adult's Name	Description
______	______________________________ ______________________________
______	______________________________ ______________________________
______	______________________________ ______________________________

	Adult's Name ______	Adult's Name ______	Adult's Name ______
2. Would you say that (NAME)'s alcohol or drug abuse would be characterized as:			
Addictive, that is a physiological dependence on alcohol or drugs	____ 1	____ 1	____ 1
Chronic, that is, long-term, continual use of alcohol or drugs not involving a physical dependence	____ 2	____ 2	____ 2
Sporadic or episodic, may go long periods without using any alcohol or drugs and then engages in intense short-term use	____ 3	____ 3	____ 3
Occasional use	____ 4	____ 4	____ 4
Other (describe)	____ 5 ______	____ 5 ______	____ 5 ______
Don't know	____ 8	____ 8	____ 8
3. Did (NAME) acknowledge abuse of alcohol or drugs at the time of the maltreatment?			
Yes	____ 1	____ 1	____ 1
No	____ 2	____ 2	____ 2
Don't know	____ 8	____ 8	____ 8
4a. At the time of the maltreatment, was (NAME) participating in a self-help group such as AA or Narcotics Anonymous?			
a. Yes	____ 1	____ 1	____ 1
b. No	____ 2	____ 2	____ 2
c. Don't know	____ 8	____ 8	____ 8
4b. Prior to the time of maltreatment, did (NAME) participate in a self-help group such as AA or Narcotics Anonymous?			
a. Yes	____ 1	____ 1	____ 1
b. No	____ 2	____ 2	____ 2
c. Don't know	____ 8	____ 8	____ 8

	Adult's Name ________	Adult's Name ________	Adult's Name ________
5a. At the time of the maltreatment, was (NAME) receiving medical treatment for an alcohol or drug abuse problem?			
a. Yes ________	____ 1	____ 1	____ 1
b. No ________	____ 2	____ 2	____ 2
c. Don't know ________	____ 8	____ 8	____ 8
5b. Prior to the time of maltreatment, had (NAME) ever received medical treatment for an alcohol or drug abuse problem?			
a. Yes ________	____ 1	____ 1	____ 1
b. No ________	____ 2	____ 2	____ 2
c. Don't know ________	____ 8	____ 8	____ 8
6a. At the time of the maltreatment, was (NAME) receiving psychiatric, psychological, or counseling services for an alcohol or drug abuse problem from an individual or facility licensed to treat alcohol or drug abuse problems?			
a. Yes ________	____ 1	____ 1	____ 1
b. No ________	____ 2	____ 2	____ 2
c. Don't know ________	____ 8	____ 8	____ 8
6b. Prior to the time of the maltreatment, had (NAME) ever received psychiatric, psychological, or counseling services for an alcohol or drug abuse problem from an individual or facility licensed to treat alcohol or drug abuse problems?			
a. Yes ________	____ 1	____ 1	____ 1
b. No ________	____ 2	____ 2	____ 2
c. Don't know ________	____ 8	____ 8	____ 8
7a. At the time of the maltreatment, was (NAME) receiving mental health or counseling services not specifically designed to treat alcohol or drug abuse problems?			
a. Yes ________	____ 1	____ 1	____ 1
b. No ________	____ 2	____ 2	____ 2
c. Don't know ________	____ 8	____ 8	____ 8
7b. Prior to the time of maltreatment, had (NAME) received mental health or counseling services not specifically designed to treat alcohol or drug abuse problems?			
a. Yes ________	____ 1	____ 1	____ 1
b. No ________	____ 2	____ 2	____ 2
c. Don't know ________	____ 8	____ 8	____ 8
8. Has (NAME) been fired from a job for alcohol or drug use?			
Since the maltreatment ________	____ 1	____ 1	____ 1
In the year before the maltreatment ________	____ 2	____ 2	____ 2
At some other time ________	____ 3	____ 3	____ 3
Never ________	____ 4	____ 4	____ 4
Don't know ________	____ 8	____ 8	____ 8

	Adult's Name ________	Adult's Name ________	Adult's Name ________
9a. Has (NAME) been arrested for an alcohol or drug abuse-related problem?			
Yes	____ 1	____ 1	____ 1
No	____ 2 (Q11)	____ 2 (Q11)	____ 2 (Q11)
Don't know	____ 8 (Q11)	____ 8 (Q11)	____ 8 (Q11)
9b. When was (NAME) most recently arrested?			
Since the maltreatment was reported	____ 1	____ 1	____ 1
In the year before the maltreatment was reported	____ 2	____ 2	____ 2
At some other time	____ 3	____ 3	____ 3
10. What was (NAME) most recently arrested for? (DON'T READ RESPONSES)			
Possession of illegal drugs	____ 1	____ 1	____ 1
Sale/distribution of illegal drugs	____ 2	____ 2	____ 2
Driving while intoxicated	____ 3	____ 3	____ 3
Vagrancy, disorderly conduct or other charge in which intoxication was a factor	____ 4	____ 4	____ 4
Other charge (specify)	____ 5 ________	____ 5 ________	____ 5 ________
Don't know	____ 8	____ 8	____ 8
11. Do you have a medical or psychological report describing (NAME)'s alcohol or drug abuse problem?			
Yes	____ 1	____ 1	____ 1
No	____ 2	____ 2	____ 2
12. Have you or any other caseworker spoken with any health/mental health professional concerning (NAME)'s problem?			
Yes	____ 1	____ 1	____ 1
No	____ 2	____ 2	____ 2
13. Does (NAME)'s use of alcohol or drugs prevent him/her from doing any of the following? (CIRCLE ALL THAT APPLY.)			
a. Shop	____ 1	____ 1	____ 1
b. Prepare meals	____ 2	____ 2	____ 2
c. Go to work	____ 3	____ 3	____ 3
d. Supervise children	____ 4	____ 4	____ 4
e. Get children to school	____ 5	____ 5	____ 5
f. Other (specify)	____ 6 ________	____ 6 ________	____ 6 ________
g. None of above	____ 7	____ 7	____ 7

CHECK CASE SUMMARY.

Are there any additional adults with substance abuse (Row 7) who also have 'X' in shaded areas (Rows 3-5)?

YES .... GO TO 6B, NEXT ADULT
NO .... CLOSING

(CLOSING)
That concludes this interview. Thank you again for your help. We greatly appreciate it.